Primary Care Nursing: A Study Exploring Key Issues for Future Developments

PRIMARY CARE NURSING: A STUDY EXPLORING KEY ISSUES FOR FUTURE DEVELOPMENTS

A project funded by the SHSSB, WHSSB, CAWT, and the NEHB

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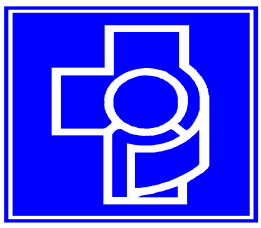
March 2001

Southern Health & Social Services Board



DEVELOPMENT OF PRIMARY CARE NURSING PROJECT

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Acknowledgements

This project was commissioned by the Western and Southern Health and Social Services Boards and funded by these organisations with some financial assistance from Co-operation and Working Together (CAWT) and the North Eastern Health Board in the Republic of Ireland.

The research team are very grateful for the time, interest, advice and commitment of members of the Steering Group. We would also like to acknowledge the help and support provided by Carmel Ming, Western Health and Social Services Board.

Deirdre Fitzsimons and Antoinette Doocey, Ms Catherine Curry and Ms Mary Curran, ensured that the Steering Group and the Research Team were kept aware of issues of relevance for services in the Republic of Ireland. We would like to thank them for their diligence.

The Steering Group would also like to acknowledge the time, co-operation and personal and professional investment of those members of the public, community nurses and general practitioners who took part in this study.

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EXECUTIVE SUMMARY

Project Rationale

This project was undertaken to explore possible developmental directions for primary care nursing in the 21st century. The setting for the study was two Board areas in Northern Ireland (The Western Health and Social Services Board and The Southern Health and Social Services Board) and two Board areas in the Republic of Ireland (The North Eastern Health Board and The North Western Health Board).

The rationale for this project was driven by a number of factors:

- The recent and ongoing reviews of community nursing in Northern Ireland and the Republic of Ireland;
- The debate within and between the professions in Ireland and the United Kingdom on the role of the various groups of nurses and midwives working in the community and the increase in specialist roles;
- The developing policy agenda around Fit for the Future, Public Health, Community Development, Targeting Health and Social Need, the Commission on Nursing Report and the support for a primary care centred service;
- The education reforms emanating from the Irish Commission on Nursing, the UK post registration education and practice and the debate on specialist practice;
- The need for a managed development agenda and informed commissioning and clinical governance strategies for primary care nursing;
- The recognition that nurses make up the largest number of 'hands on' health professionals working in the community;
- A sense among community nurses that they require support and direction in a period of intense change;
- The need to encourage North-South collaboration in primary care.

This report consists of several sections: a literature review highlighting recent and relevant articles, papers and policy directives; methodological aspects of the study and; conclusions and action points of relevance to practice and policy in primary care generally and primary care nursing in particular.

Aims

The aims of the project arose from the above rationale. In brief they are:

- To review the role and function of primary care services and community nursing with reference to developments in practice, education, research and policy;
- To explore possible models and organisational structures for the future delivery and development of primary care nursing.

These aims will be discussed in greater detail in the main body of the report.

Background

This study aimed to build on previous and current research findings and policy directives. The literature review formed the basis for informing the study's rationale, design, data collection plan and data analysis plan.

Over the last decade the most radical changes within the health services have taken place in primary care. In the UK, many of the reforms have been in response to the previous Conservative government's initiatives (DoH, 1989; DoH 1992). The Thatcher administration expressed a commitment to a primary care-led NHS and this stimulated wide debate about the future direction and development of the service. The debate was summarised in the report *Primary Care: The Future* (NHS Executive, 1996), which informed the White Papers *Choice and Opportunity – Primary Care: the Future* (Health Departments of Britain, 1996) and *Primary Care: Delivering the Future* (DoH, 1996). In the Republic of Ireland too, there has been a reduction in hospital length of stay and an increase in day care and out patient care. There has also been an emphasis in recent years on the downsizing of large psychiatric and mental handicap hospitals, with the concomitant shift in care to the community.

These policy initiatives have sent clear messages of commitment to:

- The promotion of high quality care;
- User-sensitive primary care services;

- The organisation of services to meet local need;
- Flexible employment opportunities.

In the UK, the Labour government came into power in May 1997 pledging to dismantle the internal market structure of the NHS and abolish GP fundholding. The proposals to enact these changes were outlined in the White Paper *The New NHS: Modern and Dependable* published in December 1997. The Northern Ireland version of these proposals was presented in *Fit for the Future* (DHSS, 1998) but due to the political uncertainty around the The Northern Ireland Assembly this report has not been actioned. Furthermore, three years after the Labour Government came into office, GP Fundholding is still intact in Northern Ireland.

Nurses are acknowledged as having an important part to play in shaping the overall future of primary care, most notably by taking a leading role alongside GPs in the Primary Care groups envisaged in *The New NHS: Modern and Dependable* (DoH, 1997), *Fit for the Future* (DHSS, 1999) and *Valuing Diversity* (DHSS, 1998). In the Republic of Ireland *The Commission on Nursing* (1998) recognised the role nurses have to play in the future delivery of high quality community care. The changes proposed within these documents offer opportunities for nurses to build partnerships, examine critically their current practice and acquire competencies to fulfil roles aimed at ensuring user-sensitive, safe and cost-effective practice.

Methodology

A multi-method approach was adopted for the study. It will be outlined in full in the main body of the report. Essentially the project had three phases:

Phase 1:

- Completion of a comprehensive literature review;
- Organisation of five focus groups;
- Semi-structured interviews held with senior policy makers in Northern Ireland and the Republic of Ireland.

Phase 2:

- Postal Delphi questionnaire to all those involved in the focus groups. This took the form of a questionnaire formulated from issues arising in the literature review and in the Phase 1 focus group discussions.

Phase 3:

- The results from two rounds of the Delphi questionnaire were used as a basis for a Consensus Conference involving all those who had participated in Phases 1 and 2 of the study.

Findings

Findings within the following areas of primary care are outlined in greater detail in the main body of the report. These relate to:

A. The Commissioning of Health and Social Care - issues concerning the skills required of community nurses in relation to commissioning services and remuneration for this role;
B. Leadership – issues regarding leadership within community nursing;
C. Generic and Specialist Roles – the effect of specialisation within community;
D. Clinical Governance – issues of accountability and lead roles;
E. Teamwork – Multidisciplinary teamwork, role overlap, role conflict and role confusion;
F. Working with the Public – issues highlighted by public representatives within the study;
G. Education – multidisciplinary education – the balance between academic competencies and practical competencies;
H. Communication – communication between and within the primary care team and other agencies;
I. Nurse Prescribing – the call for new formularies and expansion of the prescribing role;
J. New Ways of Imparting Information – exploiting new technologies for the benefit of clients, families and the profession;

K. Targeting Health and Social Need – the nurses' existing and potential public health role;

L. Raising public and professional awareness - developmental opportunities for community nursing.

Recommendations

In order to meet new challenges and to be prepared for new roles the following action points are recommended:

A. Recommendations Regarding the Commissioning of Health and Social Care

Recommendation 1
Nurses and midwives must be resourced to engage in local commissioning arrangements

ACTION: Commissioners/Trusts/Practitioners

Recommendation 2
An education and development programme should be provided to assist nurses and other health and social services personnel to engage in the commissioning process, differentiated at the following levels:

1. General raising of awareness of the commissioning agenda and process;
2. Participation in local commissioning groups;
3. Full time- commissioning and public health roles.

ACTION: Commissioners/ Education Providers

Recommendation 3
A proportion of nurses and midwives should be facilitated to gain experience and to pursue full-time careers within commissioning bodies.

ACTION: Commissioners/Professional Organisations

B. Recommendations Regarding Leadership

Recommendation 1
In community nursing, leaders are required who are prepared to engage with individuals and organisations in a range of formal and informal situations.

ACTION: Educator Providers/Practitioners

Recommendation 2
Leaders must be able and willing to appraise critically and audit their own practice and that of others while supporting the development of knowledge and practice to meet standards of higher-level practice. (See UKCC Pilot Standards - Appendix)

ACTION: Practitioners/Trusts

Recommendation 3
Career development opportunities should exist for those nurses who show leadership and nurse consultant potential. While adhering to equal opportunities principles, a 'fast-track' approach should be considered for future community nurse leaders.

ACTION: Trusts/ Commissioners/Professional Organisations

Recommendation 4
Leadership potential should be developed and resourced at all levels in community nursing.

ACTION: Commissioners/ Trusts

C. Recommendations Regarding Generic and Specialist Roles

Recommendation 1
Because of the dynamic nature of the health and social care system there is a requirement to evaluate continually the balance between generic and specialist skills required of each practitioner.

ACTION: Practitioners/Trusts/Commissioners

Recommendation 2
Comments from public representatives highlight their desire to have contact with one main nurse who has an overview of their individual needs and those of the family. This requires one nurse to have an overview of the health and social care inputs into the patient's care, to be prepared to co-ordinate interventions, and to be knowledgeable about onward referral in a timely and appropriate manner. The patient's main nurse should retain continuing responsibility for the care of the patient including the evaluation of specialist nursing inputs into the care plan.

ACTION: Practitioners/Trusts/Commissioners

Recommendation 3
There is evidence that specialist nurses make a significant contribution to better health outcomes, reduced hospital admission and lower complication rates. Commissioners and health planners, as a matter of priority, should review current provision and establish a template for the development of specialist services to local populations.

ACTION: Commissioners/Trusts

Recommendation 4
The review suggests that communication between nurses working in the community and those in secondary care or with other agencies is not good. This requires to be addressed.

ACTION: Commissioners/Trusts/Practitioners

Recommendation 5
The current inconsistencies in the employment and remuneration of Practice Nurses compared to Treatment Room Nurses needs to be addressed. It is recommended that Practice Nurses are funded 100% by the HPSS.

ACTION: DHSS&PS/Commissioners

D. Recommendations Regarding Clinical Governance

Recommendation 1
Community nurses must be given the opportunity to take lead roles in clinical governance

ACTION: Commissioners/ DHSS&PS/DoH&C

Recommendation 2
For most nurses a role in clinical governance will be about building upon and linking together many of the activities they are already involved in such as clinical audit, clinical supervision, evidence based practice and continual professional development.

ACTION: Trusts/Practitioners

Recommendation 3
To participate actively in clinical governance, nurses require an explicit and systematic approach to the development of practice with clear lines of professional accountability and clinical leadership.

ACTION: Trusts/Practitioners

E. Recommendations Regarding Teamwork

Recommendation 1
Through quality education and experience there is a need to develop a sound understanding of the inter-disciplinary approaches to health and social welfare.

ACTION: Education Providers/Trusts/Practitioners

Recommendation 2
Community nurses must develop the interpersonal and teamwork skills that allow for collaboration with others in service delivery and problem solving.

ACTION: Trusts/Education Providers/Practitioners

Recommendation 3
Nurses must work collaboratively and understand the viewpoint and experience of others while remaining aware of the limits of others' competence and of their own.

ACTION: Trusts/Education Providers/Practitioners

Recommendation 4
For the benefit of the health and social wellbeing of the population, community nurses must form strategic alliances with other agencies such as housing, education, roads, voluntary agencies and the police.

ACTION: Trusts/Practitioners

Recommendation 5
In the commissioning of services, specifications for service should highlight, where appropriate, the requirement for effective multi-skilling, and multi-disciplinary teamwork.

ACTION: Commissioners

F. Recommendations Regarding Public Involvement

Recommendation 1
Nurses of the future have to work harder at involving the public in planning and delivering services;

ACTION: Practitioners

Recommendation 2
Community nurses must also involve users of health and social services in ways that increase the user's resources, capacity and power to influence those factors affecting their health and well-being.

ACTION: Practitioners

Recommendation 3
Nurses have a special relationships with the public and this demands a readiness to ask people about their experiences of health and how they want their care needs met

ACTION: Practitioners

Recommendation 4
Commissioners and Trusts must create a climate and culture that is responsive to public involvement, reflected in the resources, timescales, information exchange and willingness to support individual practitioners in their public engagement.

ACTION: Commissioners/Trusts

Recommendation 5
Nurses at Board level should invest in developing strategies for involving the public in service planning and provision.

ACTION: Commissioners

G. Recommendations Regarding Education

Recommendation 1
Community nurses should continue to share educational content with other disciplines.

ACTION: Education Providers/Practitioners

Recommendation 2
There are skills that are generic to the whole primary care team. These include: clinical skills, communication, ethics and professional behaviour, record keeping, management techniques, patient education, public health, and community development. Consideration should be given to these being taught in a multidisciplinary programme.

ACTION: Education Providers/Practitioners

Recommendation 3
Integrated professional educational programmes should be established, incorporating the following principles:

- standardised professional standards for the same clinical skill;
- differential standards for specialist skills;
- criteria for the practice of clinical skills to maintain competence;
- mechanisms for testing and revalidation of skills.

ACTION: Practitioners/Education Providers/Professional Bodies.

H. Recommendations Regarding Communications

Recommendation 1
Communication between community nurses and GPs is perceived as being good. However, every effort must be made to ensure this is improved further.

ACTION: Trusts/Practitioners

Recommendation 2
Commissioners should call for communication audits to be carried out on a regular basis in their health board area.

ACTION: Commissioners

Recommendation 3
Multidisciplinary education and public involvement in decision making will aid greatly the establishment of robust communication networks.

ACTION: Education Providers/Practitioners/Trusts

I. Recommendations Regarding Nurse Prescribing

Recommendation 1
The nurse prescribing formulary needs to be expanded to include a wider spectrum of treatment and prescribing rights extended to specialist nurses and practice nurses

ACTION:DHSSPS/Commissioners

Recommendation 2
85.7% of the study's public representatives wanted nurses to be able to prescribe medication within a GP practice

ACTION:DHSSPS/Commissioners/Practitioners

J. Recommendations Regarding New Ways of Imparting Information

Recommendation 1
Commissioners and managers have to undertake a more proactive approach to consider how such initiatives can be developed, exploiting the use of modern communication and information technology for service delivery.

ACTION: Commissioners/Trusts

Recommendation 2
Community nurses must be educated to use health informatics and computer systems to better support clients, families and colleagues

ACTION: Education Providers/Practitioners/DHSSPS

K. Recommendations Regarding Targeting Health And Social Need.

Recommendation 1
Community nurses must continue to be supported to develop the public health component of their role.

ACTION: Practitioners/Trusts

Recommendation 2
Commissioners must contribute to the reduction or elimination of existing inequalities in health and social wellbeing by improved targeting of strategies and services

ACTION: Commissioners

Recommendation 3
Community nurses must bring about greater participation by communities and individuals in articulating and responding to their health and social needs

ACTION: Practitioners

L. Recommendations Regarding Raising Professional Awareness

Recommendation 2
Links between locality forums, the Commissioner and other professional groups within the HPSS should be fostered.

ACTION: DHSSPS/Commissioners

Recommendation 1
Nurses and midwives should be encouraged to organise into locality forums and specialist groupings (where appropriate) to consider and articulate a resolved view on health and social care issues.

ACTION: DHSSPS/Commissioners

A REVIEW OF RELEVANT POLICY AND PRACTICE LITERATURE

Introduction

Over the last decade the most radical changes within the NHS have taken place in primary care. Many of the reforms have been in response to previous Conservative government initiatives (DoH, 1989; DoH 1992). The Thatcher administration expressed commitment to a primary care-led NHS and this stimulated wide debate about the future direction and development of the service. The debate was summarised in the report *Primary Care: The Future* (NHS Executive, 1996), which informed the White Papers *Choice and Opportunity – Primary Care: the Future* (Health Departments of Britain, 1996) and *Primary Care: Delivering the Future* (DoH, 1996). In the Republic of Ireland too, there has been a reduction in hospital length of stay and an increase in day care and out patient care. There has also been an emphasis in recent years on the downsizing of large psychiatric and mental handicap hospitals, with the concomitant shift in care to the community.

These government papers sent clear messages of a commitment to:

- The promotion of high quality care;
- User-sensitive primary care services;
- The organisation of services to meet local need;
- Flexible employment opportunities.

The latter created new terms of employment enabling primary care professionals to use their skills to the full. To facilitate this flexibility, legislative changes were required and these were made possible through the NHS (Primary Care) Act passed in March 1997. This led to the setting up of pilot projects to test the effectiveness of new models of primary care delivery. The Act was subsequently introduced in Northern Ireland as the NHS (Primary Care) Order (DHSS, 1997).

Alongside these policy initiatives were a range of documents produced in Northern Ireland that reflected the health and social service model of primary care that existed in

the Province (DHSS, 1997; DHSS, 1990a; DHSS, 1990b; DHSS, 1995; DHSS, 1996). However, in general the broad primary care themes and principles outlined in these documents are consistent with the overall policy orientation presented by the Department of Health in London. In particular, the development of the national vision for a primary care-led service in Northern Ireland is one of the underlying principles of the Regional Strategy for 1997-2002.

> *The concept of primary care led service... will shape the way Boards commission service, the way trusts provide services and of course the way primary care itself will operate in the future. This in turn will allow services to become responsive to patients and clients since decisions about the service they need will be taken as close to them as possible. We need to build on the integrated Health and Social Services Structure and encourage a multidisciplinary approach with the Primary care team.*
>
> (Moss, 1996).

This call represented the emergence of exciting new roles for community nurses, midwives and health visitors who occupy a position at the centre of the network of care. These roles will provide greater career satisfaction and are pivotal for the smooth transfer of care from the acute sector to the community.

> *The growing shift of care from acute hospitals and long stay institutions to community settings has had a dramatic impact on community nursing… The increase in day surgery, along with the reduction in the length of hospital stay is resulting in a greater 'turnaround' in the use of acute beds. Consequently, more people with increasingly complex needs are now being cared for in their own homes* (DHSS, 1996a)

The Labour government came into power in May 1997 pledging to dismantle the internal market structure of the NHS and abolish GP fundholding. The proposals to enact these changes were outlined in the White Paper *The New NHS: Modern and Dependable* published in December 1997. The Northern Ireland version of these proposals was presented in *Fit for the Future* (DHSS, 1998).

Nurses are acknowledged as having an important part to play in shaping the overall future of primary care, most notably by taking a leading role alongside GPs, social workers and

others in the Primary Care groupings envisaged in *The New NHS: Modern and Dependable* (DoH, 1997) and in *Fit for the Future* (DHSS, 1999). In the Republic of Ireland *The Commission on Nursing* (1998) recognised the role nurses have to play in the future delivery of high quality community care. The changes proposed within these documents offer opportunities for nurses to build partnerships, examine critically their current practice and acquire competencies to fulfil roles aimed at ensuring user-sensitive, safe and cost-effective practice.

This review aims to summarise the recommendations of primary care policy documents produced since 1996; present examples of how these recommendations have informed strategic plans and; highlight future challenges and opportunities for nursing in the primary care agenda.

Defining Primary Care

Primary health care has been defined as;

> *"a basic level of health care that includes programmes directed at the promotion of health, early diagnosis of disease or disability, and the prevention of disease. Primary health care is provided within the community to people living within a particular geographical area. In any episode of illness, it is the first patient contact with the health care system*"(DHSS, 1998).

This definition, whilst including many of the principles enshrined within the WHO declaration of Alma Ata, fails to address the interagency approach to primary care and the principle of being *"universally accessible to individuals and families in the community through their full participation"*.

The WHO philosophy of primary health care goes far beyond the individualistic approach normally seen in primary medical care. Other authors have defined primary medical care as: *"a medical concept based on the equitable availability and accessibility of good quality preventive and treatment services from a team of health workers based in the community."* (WHO, 1985). This definition appears to be at odds with that proffered by

the Research Unit in Health and Behavioural Change where primary care in its true sense equates to public health and is defined as an:

> *"organised response to the protection and promotion of human health and encompasses a concern with the environment , disease control, the provision of health education and health promotion."* (Ashton and Seymour, 1988)

This involves the employment of methods drawn not only from medical science but also behavioural and social sciences. It also focuses on populations while primary medical care focuses invariably on individuals.

Nurses, midwives and health visitors should remain the first point of contact in primary health care for co-ordinating as well as delivering care. The Report of the Standing Nursing and Midwifery Advisory Committee on the public health role of nurses stated:

> *Public health nursing… is about commissioning health services and providing professional care through organised collaboration in the NHS and society, to protect and promote health and well-being, prolong life and prevent ill health in local communities and populations.* (DoH, 1995)

The foreword to the White Paper *Choice and Opportunity* (DoH, 1996) states that the development of primary care is fundamental to maintaining and strengthening the NHS. The principles concentrate on the primary health care professionals most directly affected. While these include: GPs, dentists, pharmacists and optometrists, the paper also recognises the implications for nurses, health visitors, midwives, therapists, managers and others who are concerned with the provision of high quality primary care.

The Health Education Authority defines primary care as;

> *"Care centred around the primary health care team; care focused on primary prevention of ill health; or in the present political context, care that is commissioned by those with an understanding of primary care, for example locality commissioning between GPs in partnership with health authorities"* (HEA, 1997).

One *Primary Care Strategy* (SHSSB, 1997) states that there is no agreed definition of all the elements that make up primary care as these tend to differ depending on the needs of patients and clients, the setting in which primary care is delivered and the current arrangements in place at a local level. It identified the primary care team as:

> *"... the existing GP practice based-teams together with pharmacy, optometry and dental services. A broader appreciation however, encompasses all the traditional family practitioner services, i.e. general practice services, pharmacy, optometry and dental services, along with community nursing, health promotion, direct social services, home care in all its shapes, day care and social support services".*

For nurses, midwives and health visitors, primary care is about developing new relationships and affiliations. New responsibilities, opportunities and challenges will arise as nurses, midwives and health visitors work in these coalitions in order to secure the provision of effective community care services which respond flexibly and sensitively to the needs of individuals and the relatives and friends who care for them.

Agreeing a definition of primary care is vital. The Labour government has made a commitment to primary care and therefore any strategy needs to be clear on what the term means. Important decisions also need to be taken as to whether professionals subscribe to the narrow definition of primary care focused upon general medical practice or on a broader definition that takes account of the public health perspective? This latter stance would include not only partnerships with social services but also housing, education, police, voluntary agencies and importantly the individuals and families who make up the communities being served.

Review of Primary Care Policy Documents

To chart the progress of primary care over the recent past, this review takes account of the major government policy documents published in England and Northern Ireland from 1996 to the present. For the purpose of this report these documents are presented in chronological order (See table 1).

TABLE 1 RELEVANT POLICY DOCUMENTS

Name of Document	*Date of Publication*	*Country of Origin*	*Summary of Content*
Health & Well Being into the Next Millennium	Spring 1996	Northern Ireland	Set the strategic direction of health and social care between 1997- 2002
Primary Care: The Future	June 1996	England	Outcomes of the "listening exercise" undertaken with primary care professionals.
Choice and Opportunity: Primary Care: The Future	Autumn 1996	Health Depts of Great Britain	Brought together the debates about primary care from England, Scotland and Wales. Informed changes in legislation enacted through the NHS (Primary Care Act)
The NHS: A Service with Ambitions	November 1996	England	Set the agenda for delivering high quality, integrated health care organised and centred on the needs of individual patients.
Primary Care: Delivering the Future	December 1996	England	Sets out a series of practical proposals for action to complement the opportunities offered by the changes in legislation around primary care.
NHS (Primary Care) Act	March 1997	Pertains to the whole of the UK	Changed legislation to allow for more flexible use of General Medical Services funding.
The New NHS: Modern – Dependable	December 1997	England	The Labour Governments proposals for the future of the NHS. Presents the steps to be taken in dismantling the internal market and establishing Primary Care Groups.
Well into 2000: A Positive Agenda for Health & Wellbeing	December 1997	Northern Ireland	Sets out the Labour government's vision for improving the health and well being of the people of Northern Ireland
NHS (Primary care) Order	December 1997	Northern Ireland	Allowed for more flexible use of General Medical Services Funding.
Our Healthier Nation	February 1998	England	A document setting out proposals for the improvement of public health in England.
Fit for the Future	April 1999	Northern Ireland	A document proposing, among other things, two options for the configuration of health and social services in Northern Ireland.

Implications for Primary Care Nursing - the Role of the Primary Care Nurse

In September 1996 the DHSS Action Plan sought to clarify the role of Community Nurses, Midwives and Health Visitors in Northern Ireland. It states:

> "*The ethos of community nursing, midwifery and health visiting is to respect, value and facilitate growth, development and healing within individuals, families and communities. This requires practitioners to have a person-centred perspective in care delivery which respects the individual's own identity, personal beliefs, faith, culture and sexual orientation as well as promoting the individual's self esteem. To achieve this they must work in collaboration with clients and carers, other professionals and communities. They also need to recognise the ability of people to address issues relating to their own health and social care. Communities must, therefore, be given the necessary information, support and encouragement to fulfil their potential"* (DHSS, 1998).

The previous year the Health Education Authority commented that:

> "*The term primary care nurse refers to any community nurse who holds a post-registration qualification or has specific experience or training to hold a post of responsibility. It is acknowledged that the role and functions of nursing practice in primary care change"* (HEA, 1997).

Accepting these definitions, community nurses have the responsibility to co-ordinate and facilitate the best use of resources in the promotion of health and social well-being for clients and carers in ways which include - promoting health which facilitates health gain and encourages positive lifestyles; preventing ill health; working with communities in a way which enhances the life experiences of people to create environments which promote and maintain health and social well-being; empowering all patients and carers by imparting nursing skills and; supporting patients and their carers, and where necessary, advocating on their behalf.

The importance of community nursing to the new NHS has been acknowledged repeatedly. For example, Primary *Care: The Future* (DoH, 1996) states that:

> *"The delivery of good and responsive primary care would not be possible without the valuable and major consideration made by practice and community nurses, health visitors and midwives. Nurses constitute the largest clinical profession engaged in primary care with approximately 47,000 whole time equivalent*

> *qualified staff providing tens of millions of contacts with patients and carers every year in their homes, in schools and in clinics as well as GP surgeries. The biggest growth in the past ten years has been in practice nursing where numbers have increased more than four fold"* (DoH, 1996).

Similarly, nurses, midwives and health visitors have supported and pursued the principles of quality, fairness, accessibility, responsiveness and efficiency that were identified by successive governments as underpinning primary care provision.

The notion that community nursing is a unified discipline has recently been disputed (Butterworth, 1988; Hyde, 1995). Rather, it is perceived as being composed of territorially oriented factions who work in different settings, with divergent practice skills and contrasting client groups. It has been concluded that community nursing is bonded loosely by the following three factors:

1. Community nurses are UKCC registered, first level nurses;
2. Their clients are not hospital in-patients;
3. One of their main goals is health promotion

(Butterworth, 1988).

Development in the Primary Care Nurses' Role

Primary Care: The Future (DoH, 1996) stresses that primary care nurses already possess many strengths. These strengths include the fact that the primary care nurse addresses health needs assessments, health promotion and illness prevention. The paper also points out that primary care nursing services are readily available and accessible in a wide range of settings. It asserts that nurses may be the profession that is most often required by people with long-term illness or needs. Therefore, they have a wealth of knowledge and an innate sensitivity to the care needs of specific groups within the population they serve.

A discussion paper from the largest Health and Social Services Board in Northern Ireland (EHSSB, 1997) highlighted the wide range of services provided by nurses, midwives and health visitors and welcomed current and future developments of their role. They also identified areas where primary care nurses play a vital and leading function. These

included; provision of immunisation; clinical cytology and disease management; child health surveillance; nurse-led minor injury clinics; nurse-led home care schemes; and nurse-led specialist services.

Community nurses were also identified as providing care to those people in the population who were socially excluded such as homeless people or illicit drug users. Furthermore, the paper (DoH, 1996) highlights an important new development in primary care - the role of the primary care-based nurse practitioner. Working autonomously, the nurse practitioner manages a complete episode of care and may be responsible for people who have not already been seen by a GP. It has been stated that nurse practitioners:

> *"... are expanding in number. Their origins are associated with early developments with the work of GPs. They are now also increasing in A&E and outpatient departments. Given this backdrop of change, added impetus for role extension of nurses is coming from both the Government and the medical profession"* (Littlewood, 1987).

Accepting this, nurses must be careful that they do not merely accept new roles and duties delegated by medical staff no longer interested in offering these particular services. The Departments of Health must also ensure that they do not continue to pay one health care discipline for duties now carried out by another (e.g. antenatal care).

The extension and expansion of the role of the nurse to provide a greater proportion of care to the patient and informal carers has been alluded to elsewhere (DoH, 1996). Three broad areas in which nursing practice could develop in the future have been specified:

- Clinical care nursing in which nurses would deliver care in primary and community care settings. They would take up a range of enhanced roles in management and in the allocation and use of resources for providing and commissioning quality care for patients and clients;

- Public health nursing in which nurses would promote and preserve the health of individuals, families and communities. Specific functions could include; assessment

and analysis of need; individual and community health programmes; immunisation and vaccination; well person clinics; family planning clinics; health programmes for schools; clinics for the elderly.

- Specialist nursing in which nurses would provide a specialist input to primary care and expert care and advice for patients and carers. They would also provide advice, support and continuing education and training for other members of the primary care team. Furthermore, they would contribute to the promotion of research and the development of evidence based practice (DoH, 1996).

Primary Care Led Commissioning

Valuing Diversity (DHSS, 1998), the Northern Ireland strategy for nursing, midwifery and health visiting, states that the separation between the commissioner and the provider of services seeks to maximise health and social care gain. Commissioning has been defined as:

> *'A set of planned activities undertaken with the intended outcome of measurable improvement in the health and wellbeing of resident populations, involving implementation of change to secure the most effective and efficient use of resources' (p11*).

Earlier, Balogh (1996) defined commissioning as:

> *…maintaining and improving the Health and Social wellbeing of individuals and communities in Northern Ireland through the strategic and effective use of all available resources, based on an equitable and just assessment of need.*

Valuing Diversity points out that commissioning is broader than purchasing in that it embraces:

- The assessment of need and strategy development;
- The identification of priorities and investment planning;
- Service specification and contracting;
- Service monitoring activities for individuals and populations;
- The evaluation of service developments /project;
- The developments of best practice guidelines and quality standards.

One *Primary Care Strategy* (SHSSB, 1997) states that one of its aims is to ensure the rich source of information, knowledge and experience currently available within primary care teams is used effectively to influence and better inform the commissioning and decision making process.

Nurses working within primary care have a wide knowledge of the local community and therefore can make an important contribution to both needs assessment and to the design and purchase of care, all core elements in the commissioning process. The target is to create and support appropriate and effective arrangements to encourage the development of such a primary care led service. According to Bradley (1998) nurses can bring the following to the commissioning debate:

- Application of professional knowledge;
- Important source of information to support decision making;
- Identification of health and social needs;
- Advocacy on behalf of individuals and communities;
- Ensuring nursing and midwifery services are effective, evidence based and robust to audit;
- Developing quality standards, service protocols and integrated packages of care;
- Ensuring health promotion, THSN and community developments approaches are incorporated into service agreements.

Primary care professionals have expressed a 'lack of knowledge' regarding commissioning arrangements (SHSSB, 1997). There is a view that GPs who have been involved in Fundholding or Total Purchasing Pilots (TPP) are ideally placed to exploit the opportunities offered by the new commissioning proposals. However, this is by no means assured: TPPs were very restrictive in what they purchased (fundholders more so) and are not the ideal template for locality commissioning arrangements. Notwithstanding this, the need for the development of members of the primary care team including GPs for involvement in commissioning is an area of great importance.

There is some confusion as to the role nurses will take in primary care commissioning. Questions exist pertaining to: What education will primary care commissioning nurses require? How will nurses be selected to serve on primary care co-operatives (PCC)? Will they be full time or part time members of the PCC? How can one or two nurses on a PCC be aware of the requirements of the 'broad family' of community nurses? What kind of nursing advisory group will these PCC nurses require? Will their role result in the disenfranchisement of Board nurses? Will they be paid the same fee as GPs who serve on the same PCC? Will they take the lead on clinical governance on these PCCs? Can nurses chair the PCC? These and other questions illustrate the uncertainty surrounding the nurse's role in primary care commissioning.

The empowerment of nurses, midwives and health visitors within primary care teams is an essential element of the development of commissioning. These nurses, midwives and health visitors are an important source of information and advice on planning and resource constraints, overall population needs and the health and social care aspirations of the population. Community and caseload profiling should consolidate the nursing, midwifery and health-visiting role, enabling more meaningful participation in the identification and monitoring of need. However, they must do more than simply determine needs in order to shape the delivery of services. According to *Valuing Diversity* (DHSS, 1998) community nursing, midwifery and health visiting must continue to expand and develop in response to changing circumstances with the aim of providing more holistic, flexible and focused care.

Leadership

In relation to leadership, the report *Well into 2000: A Positive Agenda for Health and Wellbeing* (DHSS, 1997) sets out messages, challenges and opportunities for leaders within nursing and emphasises that the way forward is through an improved service in terms of quality. *Valuing Diversity* (DHSS, 1998) asserts that in order to fulfil these opportunities, leaders must be invested in to take forward the nursing contribution. It sets out the following characteristics which leaders within nursing must aspire to (pg31). In brief, these are as follows:

- A visionary – able to create, articulate and encourage ownership of a vision for nursing;
- A communicator – able to communicate and effectively market needs, demands and view of nurses and those they serve;
- A strategist – able to formulate and implement strategy;
- An environmentalist – able to adapt the organisation to a changing environment;
- A political operator – able to work within local, national and international priorities and to use political awareness;
- A confident leader – able to contribute fully to the development of nursing with a previous ability in empowering staff;
- A confident professional – able to be self-aware and to recognise and maximise personal impact (adapted from the Kings Fund, 1996).

Working Together: A Focus on Health and Wellbeing (DoH, 1996) states:

> *"Professional leaders must be champions of excellence with the commitment to lead the profession into the next millennium, have the foresight to anticipate future needs and influence policy development for the benefit of patients, families communities and staff"* (p33).

There are new initiatives in the development and support of nurse leaders. Speaking at the RCN Congress (2000) in Bournemouth, Alan Milburn, the Secretary of State for Health, stated that

> *Nurse consultants are the most powerful symbol for change. The first 141 nurse consultant posts have already been approved. The first nurse consultants are standard bearers for the leading role that nurses can now play. I want to see a second wave of nurse consultants to be approved this year. I will fast track those posts in priority areas like critical care, intermediate care, accident and emergency and outpatient services. By this time next year I expect the NHS to more than double the current number of nurse consultants.*
>
> (Milburn, 2000)

Generic and Specialist Nursing Roles.

The *Action Plan for Community Nurses, Midwives and Health Visitors* (DHSS, 1996) outlines the uniqueness of these professions. While all are professionally qualified and

registered with the United Kingdom Central Council (UKCC), each has its own focus and specific area of practice. The policy literature stresses consistently that, in order to provide the highest quality of care for patients or clients, community nurses and other health professionals must understand each other's roles and contributions to the delivery of care. They must also recognise the complementary nature of the role of the informal carer. Furthermore, community nurses must reflect continually upon their practice and review their role in partnership with each other and with colleagues in other disciplines to ensure that the needs of clients are responded to in the most effective way possible.

The UKCC (1994) has defined community health care nursing as a 'new discipline' with eight specialisms:

- General practice nursing
- Community mental health nursing
- Community mental handicap nursing
- Public health nursing/ health visiting
- Community children's nursing
- School nursing
- Occupational health nursing
- Nursing in the home/ district nursing.

Earlier, Butterworth (1988) had also identified eight areas of specialist practice, which he argued, comprised community nursing. However, in contrast to the UKCC, Butterworth's categories included community midwifery and excluded practice nursing. It is claimed elsewhere that there is an 'obvious list' of ten major specialist areas of community nursing, and that these are selected from a possible total of over thirty types of nurse whose practice is community based. This has the potential to confuse not only other disciplines but also the public.

Working Together: A Focus on Health and Wellbeing (DHSS, 1996) identifies eleven different specialities working within the community (p17). These are outlined as follows:

- District Nurses;

- Health Visitors;
- Community Mental Health Nurses;
- Community Learning Disability Nurses;
- Occupational Health Nurses;
- General Practice Nurses;
- School Nurses;
- Community Children's Nurses;
- Community Midwives;
- Treatment Room Nurses;
- Registration and Inspection Nurses.

The DHSS (1996) states that it is important to avoid the problem of 'too many carers visiting in one home' and that services must be co-ordinated and one key professional identified to provide the major element of care (p19).

Clinical Governance

The principles of clinical governance outlined by the Government mean that primary care professionals will need to address the quality of care given by primary care services. *Valuing Diversity* (DHSS, 1998) defines clinical governance as:

> *"… to assure and improve clinical standards at local level throughout the NHS. This includes action to ensure that risks are avoided, adverse events are rapidly detected, openly investigated and lessons learnt, good practice is rapidly disseminated and systems are in place to ensure continuous improvements in clinical care".*

The Department of Health (1998) defines clinical governance as:

> *'a framework through which NHS organisations are accountable for continuously improving the quality of their services, safeguarding high standards by creating an environment in which excellence in clinical care will flourish'*

According to a recent paper (DHSSPS 1999), clinical and social care governance is a framework within which everyone providing or commissioning services, within the HPSS of from the independent sector will be:

- accountable for continuously improving the quality of services;
- responsible for safeguarding high standards of care and treatment and creating an environment in which continuous improvement flourishes.

Targeting Health and Social Need

The Health Education Authority (DHSS, 1996) recognises that the large number of primary health care nurses in the UK represent a valuable resource for enhancing the health of the entire population. They stress that the promotion of health and preventative health care is fundamental to the role of the primary care nurse and that the potential for nurses to play a key role in helping individuals and communities on a local level to lead healthier lifestyles is immense.

More recently *Valuing Diversity* (DHSS, 1998) stressed that it is fundamental for the health and social wellbeing of the population that nursing, midwifery and health visitor resources are targeted where client needs are greatest. Likewise, nursing, midwifery and health visiting interventions must be continually assessed to ensure that they are succeeding in reducing rather than increasing variations in the health and wellbeing of the population. Moreover, nursing as a profession must deliver value for money through identifying, disseminating and applying good practice, and seeking greater effectiveness in care processes and through active involvement in uniprofessional and multiprofessional audit.

The Health of the Nation strategy (HMSO, 1992) represented a clear move away from secondary medical treatment to primary health promotion and prevention of ill health. The move to primary health care has become a cornerstone of NHS priorities and planning guidance in the last few years. Since there is evidence that those disadvantaged groups with the worst health status remain those with less access to health and social care, account must be taken of the uptake of nursing services by all groups in society.

Nurses, midwives and health visitors have a working knowledge of the myriad factors that influence the variation in health and social conditions and are capable of using best

evidence and practice to reduce this variation for the betterment of health and social wellbeing. Moreover, nurses, midwives and health visitors are in an ideal position to be aware of and influence the public's expectations regarding health. Future input should seek to raise these expectations and through research-informed practice seriously attempt to exceed the public's expectations (Lazenbatt, 1997). This will reflect credit on the increasing public health role of nurses, midwives and health visitors.

Teamwork

The white papers referred to above would suggest that within primary care nurses must continue to develop partnerships with multidisciplinary and multi-agency colleagues. The professional teams of the future will function with a range of disciplines and different levels of expertise and nurses will have to demonstrate their contribution to the health and social care agenda in an environment where there is an increasing blurring of professional roles. This will demand true collaboration with customers, consumers, providers and purchasers of care and education.

In essence, primary care is about developing new relationships and affiliations and the vision of a primary-care led service will only be realised as the nursing profession is empowered through planning and commissioning to take its place alongside multiprofessional colleagues as equal partners of the primary health care team. New responsibilities, opportunities and challenges will arise as nurses work in these coalitions in order to secure the provision of effective community care services which respond flexibly and sensitively to the needs of individuals and the relatives and friends who care for them (DHSS, 1998).

Collaborative teamwork will be a predominant feature of the modern health services. It needs to develop not only in the community but also in hospitals and where policy and commissioning decision are taken. There is much developmental work to do regarding the formulation of new teams and new team working practices. Included in this is the active involvement of clients, families and carers as part of the collaborative team. Nurses, midwives and health visitors and those planning nursing services need to be more

proactive, to explore the boundaries of practice and engage with other professions to address interprofessional and interagency issues in the health, social care and related fields and to increase their understanding about small organisational dynamics.

According to Alan Milburn (2000):

> *The old world of NHS hierarchy is giving way to a new world of equality. Equality between professions. That is what I want to see. Not nurses versus doctors. But nurses and doctors working together. Each contributing their own unique skills to a single care system. Each fulfilling their full potential. Not by working harder – but by working smarter. Modernisation is about more nurses, more doctors, more skilled professionals – but with skills used to best effect, with care delivered by teams; and with flexibility around the needs of patients.*

Culyer (1996) maintained that different members of teams must bring their own specialist skills to bear in the context of a shared problem and where there is sufficient understanding of the potential contributions from disciplines other than one's own and mutual respect for the right kind of teams to be assembled and work well together.

Public Involvement

A core element of governments' health and social care strategy is the involvement of the wider public in decisions regarding the planning and delivery of services. According to the Heathrow Debate (1994) while nurses have not been effective in working outside their professional area, in handling public opinion and in tackling public issues their voice 'is almost a whisper'. Therefore, skills in relation to community development, community empowerment and public health perspectives need to be an integral part of education at pre and post registration levels.

Educational curricula should address questions such as: how can the active participation of people in their care be achieved? Will people resent feeling that more responsibility is put back on them? Should clients/communities purchase their own health care and, if so, what kinds of nursing services will they buy?

The nursing profession's involvement in locally sensitive commissioning arrangements should ensure that the views of the Health & Social Services Council, voluntary bodies, the wider public and their representatives are actively sought and acted upon during the commissioning process.

Education

Valuing Diversity (1998) states that professional education must be responsive to the rapidly changing needs of the service and that lecturers and practitioners must embark on a lifelong cycle of learning with access to up to date information sources close to the workplace (p23).

Changing practice to meet the health care needs of the 21st century calls for fundamental changes in nurse, midwifery and health visitor education. As the practice environment changes, the education system must also adapt for *e*ducation is one of the main vehicles by which the profession moves to meet new challenges. In addition, economic imperatives have forced stakeholders to take a closer look at the returns on their investment in education. Education for education's' sake is no longer affordable. Therefore, the answer to the following question must be sought: what type of educational provision would facilitate the development of nurses, midwives and health visitors to improving the health and social wellbeing of the population in Northern Ireland?

The integration of nursing and midwifery education into higher education has created opportunities for more shared learning with other professions. This represents a challenge to our present educational programmes. There is the view that nursing should retain core nursing and midwifery programmes of training but be involved in multidisciplinary and new training programmes (Heathrow Debate 1994c). However, there is a need to address the problems associated with single discipline training. According to the Health Services Management Group (1996) there is every indication that future education will be multiprofessional based with high generic content. In this scheme, future healthcare workers, including nursing and medical students, would commence their training on a

common core programme leading to generic professionals for broad service sectors. The area of multidisciplinary education is one that has been explored within this study.

The Future of Primary Care

Judging by the sheer number of policy directives that have appeared over the last two years there is no doubt that primary care is high on the national agenda. *Primary Care: The Future* (DoH, 1996) outlines the principles of primary care, how these affect the services provided, their organisation and the areas for development. It begins to identify the changes that are needed in order to make progress and secure the kind of primary care that people want for the future. The paper concludes by outlining possible areas for action:

- Securing the Physical, human and fiscal resources necessary to deliver what is needed locally;
- Fairer distribution of resources across the country according to need;
- More equitable balance of resources between primary and secondary care;
- Developing partnerships in care with all key players within the primary care process, including clients;
- Developing professional knowledge through primary care education, training and research for clinical effectiveness;
- Patient and carer information, involvement and choice;
- Being open and honest with service users;
- Better organisation through, for example, IT and management support;
- Local flexibility so that the way in which services are delivered can be better attuned to local needs and circumstances.
- A commitment to quality, fairness, responsiveness, accessibility and efficiency;
- A public health approach which tackles health inequalities;

(DoH, 1996)

The future of primary care may lie in the development of these crosscutting themes. In relation to 'developing partnerships in care', the delivery of primary care has always been the responsibility of many different professionals and increasingly they work within teams. The multi-disciplinary team approach is becoming increasingly important and needs to be strengthened and developed further. In Northern Ireland, the DHSS *Action Plan for Community Nurses, Midwives and Health Visitors* (DHSS, 1996) outlines challenges for various groups. The paper states:

> "*To utilise the principles outlined in* ***Primary Care: The Future,*** *community nurses, midwives and health visitors, as key members of the primary care team, must take a lead and utilise fully their skills to be pro-active and to be able to respond to the needs of the community. They need to be supported and facilitated in their practice, which has implications for other involved in health and social care, there fore the following challenges are issued."*

The Department of Health and Social Services is challenged to ensure that the development of health and social services policies, and the planning and commissioning process, involve representative from nursing, midwifery and health visiting.

Alan Milburn (2000) stated

> *In primary care we have already put community nurses alongside family doctors in charge of budgets for patient care. We have done so because you know patients' needs best. Since April last year, around a thousand nurses are leading primary care groups. Nurses helping to control a budget of £20 billion in primary care groups alone.*

In the future it is envisaged that more will be done in the general community to maintain health. In the face of this nurses, midwives and health visitors will develop their roles as facilitators for community development, not only empowering individuals and communities to make best use of health and social care resources but also the wider resources devoted to issues such as the commercial interests of industry e.g. food, alcohol and tobacco, housing, education, nutrition and the environment.

It is envisaged that nurses, midwives and health visitors must work with communities in a way that enhances the life experiences of people to create environments that promote and

maintain health and social wellbeing. This includes assisting communities to be involved in decision making, assessing the health status of communities, compiling community profiles and implementing community based outreach programmes. Furthermore, because families are less cohesive, more carers are older, women are more often working, nurses, midwives and health visitors should sensitively promote and involve volunteers in a wider variety of activities that benefit both themselves and their communities.

Skills in relation to community development, community empowerment and public health perspectives need to be an integral part of education at pre and post registration levels. Educational curricula should address questions such as: How can the active participation of people in their care be achieved? Will people resent feeling that more responsibility is put back on them? Should clients/communities purchase their own health care and, if so, what kinds of nursing, midwifery and health visiting services will they buy?

As Northern Ireland enters the first year of the new millennium, there appears to be a political vacuum in terms of primary care service developments. With the re-establishment of the Northern Ireland Assembly on 30th May 2000, uncertainty remains regarding the implementation of the recommendations of Fit for the Future (DHSS, 1998; DHSS, 1999). In the mean time there is no obvious leadership or direction in primary care policy making. The enthusiasm and energy of the late 1990s has dissipated. The effect of this on the morale of primary care professionals is unknown. Nonetheless, regardless of what the new health minister may bring to the policy table, key issues such as locality commissioning, multidisciplinary and multiagency working, targeting health and social need and user involvement will always act as the glue that binds a coherent primary care service:

METHODOLOGY

Aims

The aims of the project arose from the literature. They are:

- To review the role and function of primary care services and community nursing with reference to developments in practice, education, research and policy;
- To explore possible models and organisational structures for the future delivery and development of primary care nursing.

Link to CAWT

While this project is not primarily dependent on the cross border Co-operation and Working Together programme (CAWT), it was considered important to establish and maintain a link. The connection was as follows:

- CAWT representation on the Steering Group;
- Involvement of GPs and community nurses from the Republic of Ireland in the focus groups; and
- Involvement of health care policy makers from the Republic of Ireland.

Study Design

This project used three different research approaches:

1. Focus Groups;
2. The Delphi technique;
3. Semi-structured interviews.

Focus Groups

Focus group research involves discussion with a selected group of individuals regarding their views and experiences on specific topics (Gibbs, 1998). Defining what a focus group is has always posed a difficulty in qualitative research (Kitzinger, 1994; Powell et al, 1996; Goss and Leinbach, 1996). One definition that is appropriate for the purpose of this study is:

> *"A group of individuals selected and assembled by researchers to discuss and comment on, from personal experience, the topic that is the subject of the research" (Powell et al, 1996).*

The focus groups in the present study were organised through the local Health and Social Services Boards and Trusts in both Northern Ireland and the North Eastern and North Western Health Boards in the Republic of Ireland. The sample was made up of thirty-eight primary care nurses, fourteen general practitioners (GPs) and eight public representatives.

Nurses were purposefully selected from all specialities of community nursing. Purposive sampling techniques (Parahoo, 1997) mean that respondents were selected to suit the purpose of the study and who could contribute to the discussion from their specialist background. Members of the Research Steering Group helped identify the sample. Potential participants had to meet the criteria of being a community nurse and being willing to take an active part in the project. The following broad range of specialisms were represented:

- Practice Nurses (n=9);
- Health Visitors (n=5);
- District Nurses (n=4);
- Community Midwives (n=4);
- Community Psychiatric Nurses (n=3);
- Public Health Nurses (n=3);
- Community Learning Disability Nurses (n=2);
- Specialist Community Nurse - Palliative Care (n=2)
- Specialist Community Nurse - Diabetes (n=2);
- Specialist Community Nurse - Child protection (n=1);
- Specialist Community Nurse – Challenging behaviour nurse (n=1);
- Specialist Community Nurse - Community paediatric nurse (n=1);
- Macmillan nurse (n=1);
- Treatment room nurse (n=1);
- Nurse practitioner (n=1).

The fourteen GPs were divided equally among fundholders and non-fundholders. General practitioners were selected through contacts at Health and Social Services Boards and Health Boards. In Northern Ireland, GP locality chairs were asked to participate. Two GPs were from the Republic of Ireland.

Members of the public were recruited through Health and Social Service Councils (A government health 'watchdog' organisation). It should be stressed that those who took part were not Council representatives but ordinary members of the public who were willing to participate in the study.

The entire sample was characterised by 48 respondents from Northern Ireland and 12 respondents from the Republic of Ireland.

The focus groups were organised when the sample was invited to a seminar at two venues convenient for the participants. In an introductory session, a key speaker outlined the purpose of the day and the reasons for the study. Those present were allocated by discipline to different focus groups. There were two GP focus groups, two with community nurses and one with members of the public. The decision to separate the groups in this way was based on the possibility that some people may find the experience intimidating and may not be forthcoming in terms of their responses. On average, there was between 6-8 individuals in each group with each having a representative from the Republic of Ireland.

Each group had a trained moderator experienced in primary care and in group work. While the discussion was audio taped, a note taker was also present. Verbal consent to record information was obtained from each individual. The focus groups lasted approximately an hour to an hour and fifteen minutes, allowing each group to break naturally rather than imposing a time limit. The data were transcribed and inputted into NUD*IST, a computer software package for the analysis of qualitative data.

The Delphi Technique

The Delphi technique involves the presentation of a questionnaire to a panel of informed individuals in a specific field, in order to seek their opinion or judgement on a particular issue (McKenna, 1994). After the questionnaires are returned, the data are normally summarised and a new questionnaire is designed based on results of this summary. This 'Round Two' questionnaire is returned to each respondent indicating (from Round One) the overall group response and the respondent's own individual response. Respondents are asked to reconsider their initial response in the light of the Round One's results. Repeat rounds of this process are carried out until consensus of opinion has been reached or when no further change takes place. Consensus is normally regarded as over 50% agreement among participants on an issue, attitude or judgement (McKenna, 1994). In the present study this was not considered rigorous enough and the consensus levels was set at 75%. In other words 75% of the respondents had to have supported the issue before agreement (consensus) was claimed. For many issues the consensus rate was much higher than this.

The Delphi technique is used widely in health and social research in a variety of forms (Mead, 1991; Butterworth and Bishop, 1995; Green et al, 1999). There are many different variations of the basic Delphi technique including the 'modified Delphi' (McKenna, 1994), the 'policy Delphi' (Crisp et al, 1997) and the 'real-time Delphi' (Beretta, 1996). Few researchers use a pure Delphi approach and the various hybrids have been criticised by writers such as Sackman (1975). Nonetheless, in respect of the present study, the 'Delphi' worked well in addressing the study's aims.

Delphi Round One

The literature review and the aforementioned focus groups formed a template for the questionnaire used in Round One of the 'Delphi'. Participants who had attended the focus groups were asked to complete the Round One Delphi questionnaire. This worked well, securing a response rate of 100%.

The Round One Delphi questionnaire had a series of 38 statements about primary care (see Appendix 1). The respondents were asked to indicate their response to each of these statements on a five point scale from 'Strongly agree' to 'Strongly disagree'. The statements are illustrated in Table 2. Space was also provided under each statement for respondents to elaborate if they were so inclined: several respondents did take this opportunity.

Delphi Round Two

The second round of the Delphi comprised a questionnaire with two sections. The first section (Section A) included the original 38 statements from Round One. Provided beside each statement was an indication of the overall group response to that item and the individual's own response. In other words, each participant could see how other participants had responded in Round One and they could compare this to how they themselves had responded. Once they possessed this information, respondents were told that they could reconsider and alter their original response or leave it unchanged.

The second section of the Round Two Delphi questionnaire (Section B) was composed of the qualitative elaborations made by respondents in Round One. It was stated very clearly in the Round Two questionnaire that this was a separate section designed to explore these issues and gain consensus on them. The response rate for round two was 97% (n=58). Of the two who failed to respond, one had changed their address and one (a GP) was "too busy".

Table 2: Statements included in Delphi Round One

- In the future community nurses must work within an effective multidisciplinary team
- Multidisciplinary teamwork among community nurses is an essential pre-requisite for an effective health and social care service.
- There is great potential for role conflict among members of primary care teams.
- Greater specialisation is essential for the community nurse of the future.
- Community nurses of the future have to work closely in partnership with members of the public.
- The community nurses of the future should take the lead in the identification and assessment of needs in their local population.
- Community nurses do not have the skills to take a lead role in commissioning.
- Community nurses require training and education to take on new roles in commissioning.
- Community nurses must have equal remuneration with GPs for roles in commissioning.
- Community nurses require training and education to take on new roles in health care delivery in order to meet the needs of their local population.
- There is no clear understanding of the role of the community nurse among - the Public; GPs; Social Workers; Physiotherapists; Occupational Therapists.
- In the future community nurses should be educated with. GPs; Social Workers; Physiotherapists; Occupational Therapists; Dieticians; Dentists.
- Strong leadership is essential for the development of community nursing.
- Currently there is strong leadership to carry nursing into the future.
- Staff recruitment and retention could inhibit the development of community nursing in the future.
- Community nurses of the future will be less involved in patient care and more involved in management.
- There is good communication between community nurses and acute hospital staff; GPs; other outside agencies.
- Community nurses must be given the opportunity to lead on clinical governance.
- Community nurses must be accountable for the quality of service they provide.
- The community nurse is ideally placed to take a lead role in public health/health promotion.
- Community health services in the North and South of Ireland must establish stronger links.
- Primary care will undertake an increasing proportion of the work done in hospital or secondary care settings.
- With increasing access to technology, the proportion of investigations and diagnostic tests within Primary Care will increase.
- With the increase in our understanding of genetics, Primary Care will play a greater role in proactive health care/medicine.
- Primary Care is ideally placed to facilitate Community Development approaches to health and social care delivery.
- Primary Care has a key role in Targeting Health and Social Need.
- Primary Care is well resourced to take forward extra initiatives.

Table 3: Qualitative Statements included in Section B of Delphi Round 2

- Nurses need to get their own structure correct before embracing true multidisciplinary working
- Greater specialism in nursing has caused greater potential for role conflict
- If 'Fit for the Future' is implemented, there will be less potential for role conflict;
- Research and evidence based practice is essential for the future of community nursing
- There is a risk of developing too many specialists and not enough generalist nurses
- As yet, no profession has the skills required for commissioning in primary care
- Clinical supervision should be introduced for primary care nurses
- Community nursing has been a soft target in the past for reducing resources, especially staff
- GPs and community nurses should meet to discuss primary care issues on a regular face to face basis
- If nurses increase their involvement in commissioning, GPs could be squeezed out
- Role conflict among community nurses leads to unnecessary confusion for the patient who does not know what each nurse does
- Patients' expectations of community nursing are rising and this puts pressure and demands on nurses
- Multi-disciplinary education will significantly improve communication within and between health professionals
- There is a great need for nursing auxiliaries in the community
- The different employers for practice nurses and community nurses causes tensions between them
- The training and education required for community nurses to take on new roles is happening too slowly
- The medical model is a good template for the development of a primary care led model
- There are not enough good leaders in nursing
- Community nurses feel their loyalty is to their nurse manager rather than to their practice
- GPs do not fully understand all the different types of community nursing services and which nurse carries out which service
- Nurse education should not be concerned with academia but with practical nurse training
- GPs should not be dealing with nursing homes in the community; this should become a specialised nurses role
- There is a fear in community nursing that if you are too vocal and speak out, you won't get on
- Members of the public feel more comfortable dealing with the community nurse than their GP
- Members of the public prefer one type of nurse to visit them at home rather than a variety of different nurses
- Members of the public feel more confident if they are being treated by a specialist nurse
- The concept of the nurses' being able to prescribe medication within a GP practice is very appealing to members of the public
- The concept of self diagnosis from media, electronic and literature sources is popular with the public

Semi-structured Interviews

Semi-structured interviews were undertaken with senior policy makers in Northern Ireland and in the two participating Health Boards in the Republic of Ireland. A total of 34 individuals were interviewed, including:

- Chief Executives of Health and Social Services Boards;
- Chief Nurses;
- Trust Chief Executives;
- Trust Directors of Nursing;
- Nursing Officers (DHSS);
- Health and Social Services Executive Representatives;
- National Board for Nursing, Midwifery and Health Visiting for Northern Ireland;
- University Heads of Nursing;
- Senior Officers of the Royal College of Nursing;
- Fundholding GPs;
- GP Commissioners;
- Directors of Public Health.

A semi-structured interview schedule was used for each interview. The questions were formulated from the literature, the results from the focus groups and the Delphi questionnaires. Each interview lasted approximately half an hour to an hour and with the consent of each respondent, the interviews were audio taped. The data were transcribed and inputted into the NUD*IST software package.

Consensus Conference

As the study was approaching its conclusion, a consensus conference was organised where all those previously involved in the study were invited to participate. Presentations were made from invited speakers on relevant research and policy directives in primary care – especially those that had arisen since the study had commenced.

Some issues had remained unresolved from Round Two of the 'Delphi' and in order to see if it was possible to gain consensus of opinion on these, participants were allocated to

one of six workgroups. Each workgroup was given a number of issues to discuss and members were asked to try to reach a consensus opinion. These discussions were recorded by note takers and analysed using content analysis.

FINDINGS

The results section of this report is divided into the following sections:

M. Findings regarding the Commissioning of Health and Social Care;
N. Findings regarding Leadership;
O. Findings regarding generic and specialist roles;
P. Findings regarding Clinical Governance;
Q. Findings regarding Teamwork;
R. Findings regarding working with the Public;
S. Findings regarding Education;
T. Findings regarding Communication;
U. Findings regarding nurse prescribing
V. Findings regarding New Ways of Imparting Information
W. Findings regarding Targeting Social Need;
X. Findings regarding raising professional awareness

These sections will include results from each stage of the study along with learning objectives and action points.

A. Findings Regarding the Commissioning of Health and Social Care;

Within the present study the Delphi questionnaires sought agreement or disagreement from respondents on a number of statements regarding commissioning. Their responses were as follows: (CN = Community Nurse; PR = Public Representative)

Table 4: Delphi responses to commissioning statement 1

Community nurses do not have the skills to take a lead role in commissioning

	Round 1 Responses (%)				Round 2 Responses (%)			
	GP	CN	PR	Overall	GP	CN	PR	Overall
Agree	64.3	29.0	0	33.4	61.5	29.0	14.3	33.5
Undecided	14.3	7.9	25.0	11.7	15.4	10.5	28.6	13.3
Disagree	21.4	63.2	75.0	55.0	23.1	60.5	57.3	50.0

Table 5: Delphi responses to commissioning statement 2

Community nurses require training and education to take on new roles in commissioning

	Round 1 Responses (%)				Round 2 Responses (%)			
	GP	CN	PR	Overall	GP	CN	PR	Overall
Agree	100.0	89.4	87.5	81.6	100.0	97.4	100.0	98.3
Undecided	0	7.9	0	5.0	0	2.6	0	1.7
Disagree	0	2.6	12.5	10.0	0	0	0	0

Table 6: Delphi responses to commissioning statement 3

Community nurses must have equal remuneration with GPs for roles in commissioning

	Round 1 Responses (%)				Round 2 Responses (%)			
	GP	CN	PR	Overall	GP	CN	PR	Overall
Agree	42.9	94.8	87.5	81.6	46.2	97.4	85.7	84.5
Undecided	21.4	2.6	12.5	8.3	15.4	0	0	3.4
Disagree	35.7	2.6	0	10.0	38.5	2.6	14.3	12.0

These findings are enhanced by the discussion that took place within the focus groups. General practitioners commented on nurses having key roles in commissioning and they made the following points:

- *Nurses definitely have a role in needs assessment and commissioning;*
- *If nurses get involved in commissioning, GPs will be pushed out;*
- *The nursing profession is well ahead of others with these skills at present;*
- *Nurses must understand that this is not a role for them.*

Community nurses also offered their own perspectives on nurses having a role in commissioning. Comments were as follows:

- *Whoever is fit for the job should take on the role;*
- *Consensus by the nurses on who should take on the role is the best way forward;*

- *Nurses have been keeping GPs right all along;*
- *Nurses are so busy on the ground that they don't have time for commissioning;*
- *There is confusion over primary care groups and commissioning among nurses at present.*

The results from the Delphi and the focus groups are enriched by the interviews with policy makers. These are outlined below:

- *In some instances community nurses will be able to take a lead role in commissioning. It is more about the right person in the right place at the right time though. However, people who have been community based for many years will need some exposure to the acute sector* (Director of Nursing);

- *The person who takes the lead role should be the person who is most skilled. I'm not saying the community nurse nor am I saying the GP. But the person who has the most skill and the most knowledge* (Director of Nursing);

- *Community nurses can take a very major role in commissioning. It would be a mistake to think that nurses were the only people involved in commissioning. Obviously the contribution of general practice, public health and the community itself, all have a contribution to make* (Chief Nurse);

- *With training, community nurses could make significant contributions to commissioning. The difficulty to date with community nurses is that their education and their exposure may have been a bit limited for the broader commissioning requirements* (Chief Exec – Board level);

- *One of the issues causing concern is the knowledge and skills required to commission and lead services. This is something which needs developed because of the lack of research and development in the primary care sector. Community nurses have a role to play in commissioning but some development work on skills and knowledge must take place first* (Senior Nurse Educator);

- *Community nurses have a very important role to play in commissioning because of their wealth of experience. They may not have had a place at the table in the past but this time they will be there and they will be prominent* (Senior Nurse Manager, DHSS);

- *In the future there is potential for community nurses. Commissioning has to be a collaborative thing between GPs, social worker and all the other health professionals in primary care. Community nurses have so much knowledge about their community, the needs of their clients, the needs of carers* (Director of Nursing);

- *Community nurses are perfectly able to take the lead role in commissioning. Obviously it very much depends on the individual and their ability to communicate and get on with the rest of the people at the time. But it shouldn't be any single individual or individual profession that has got it right. It really should be a team operation* (Senior Nurse Manager, HSSE);

- *The RCN point of view is that we have been fighting very hard to have community nurses involved in commissioning. You can no longer differentiate the community nursing role for the future into the provider role and the commissioning role. It is clear that the two will feed off each other. Community nursing must be involved in the commissioning process* (Royal College of Nursing).

Skills needed by community nurses to take on a role in commissioning as outlined by senior policy makers included the; ability to think laterally; ability to think outside the boundaries of the profession; ability to focus on what is good for the patient; negotiation skills; decision making skills; knowledge of the public health agenda; local knowledge of the population; diplomacy and directing skills; chairing boards and meetings; research and analytical skills; understanding of local and national politics, public bodies, voluntary and statutory sector, provision of services; IT skills; excellent communication skills; ability to operate in a broader view rather than having a single locality focus; demonstrate leadership potential; ability to co-ordinate a multi-disciplinary workforce; needs assessment skills; ability to manage budgets and funds effectively; people management skills; business planning, costing, financing, performance indicating skills; strategic thinking and planning skills.

Policy maker views on whether nurses have these skills at present:

- *There is a proportion of nurses, in particular health visitors, who should have a range of these skills. Not sure how well developed they are among practice nurses and district nurses but it appears that we need to develop more active levels among the nursing community* (Chief Nurse);

- *I think there are people who have but I think the core of the workforce that would be at the centre of carrying these agenda forward, need significant investment in developing these skills* (Chief Exec – Board level);

- *Community nurses have these skills to a certain extent but I feel they need to be honed up, particularly the negotiation skills* (Director of Nursing);

- *Not all have these skills, but many have* (Director of Nursing);

- *Very limited skills in this area. They are not the only profession though. The same would be said of GPs. I actually think that community nurses might have a head start* (Director of Nursing);

- *Nurses don't have these skills at present. They get bogged down and pre-occupied with the day-to-day pressures and work. We need to start training them for a commissioning role* (Director of Nursing);

- *Nurses are as well qualified as anyone else to take on this role. If you asked me how many people in Northern Ireland have the skills to be good commissioners, I would tell you very few because up until now commissioning has been concentrated at Board level* (Senior Nurse Manager, HSSE);

- *Where you have got community nurses who have formed themselves in integrated nursing teams who are good at determining health needs, drawing up a plan against it and delivering the care necessary then these nurses are already knowledgeable about how these processes work. In terms of their local population they have been commissioning services* (RCN).

Policy maker views on equal remuneration for nurses and GPs for roles in commissioning:

- *It will never happen – its not very realistic* (Director of Nursing);

- *As a matter of principle they should be equally remunerated and in the sense of having their expertise recognised in some form monetary worth to them* (Chief Nurse);

- *Its about a fair salary for the job rather than finding little bits and pieces to pay them for* (Chief Exec – Board level);

- *Equal pay for an equal job. Unquestioningly* (Director of Nursing);

- *This is unrealistic. The medical profession are an exception to all the rules within the Health Service* (Chief Exec – Board level);

- *They would be paid significantly for what they do but I would not see an equal remuneration* (Senior Nurse Manager, DHSS);

- *Of course they should receive equal remuneration. There is absolutely no question about it but the chances of them getting it is so remote* (Director of Nursing);

- *In principle this should happen. The difficulty is that nurses are employees whereas GPs are independent contractors* (Senior Nurse Manager, HSSE).

While health care policy in the Republic of Ireland has not explicitly identified locality commissioning as a key aspect of future service commissioning, it was clear that Irish community based nurses are strengthening their role in the Health Boards and the Department of Health and Children. Here they are involved actively in population needs assessment and monitoring services. Furthermore, many of the skills needed by community nurses to take on a role in commissioning (identified above) are in the repertoire of Irish public health nurses. These include, the ability to focus on what is good for the patient; negotiation skills; decision making skills; knowledge of the public health agenda; local knowledge of the population; diplomacy and directing skills; understanding of local and national politics, public bodies, voluntary and statutory sector, provision of services; communication skills; demonstrate leadership potential; ability to co-ordinate a multi-disciplinary workforce and people management skills.

B. Findings Regarding Leadership

Within this present study the Delphi questionnaires sought agreement or disagreement from respondents on a number of statements regarding leadership. Their responses were as follows:

Table 7: Delphi responses to leadership statement 1

Strong leadership is essential for the development of community nursing

	Round 1 Responses (%)				Round 2 Responses (%)			
	GP	CN	PR	Overall	GP	CN	PR	Overall
Agree	100.0	89.5	100.0	93.3	92.3	100.0	100.0	98.3
Undecided	0	5.3	0	3.3	7.7	0	0	1.7
Disagree	0	5.3	0	3.3	0	0	0	0

Table 8: Delphi Responses to leadership statement 2

Currently there is leadership to carry community nursing into the future

	Round 1 Responses (%)				Round 2 Responses (%)			
	GP	CN	PR	Overall	GP	CN	PR	Overall
Agree	14.2	18.4	37.5	20.0	15.4	13.1	28.6	15.5
Undecided	50.0	28.9	37.5	35.0	46.2	44.7	42.9	44.8
Disagree	35.7	52.7	25.0	45.0	38.5	42.1	28.6	39.6

Discussion points from the focus groups led to several issues being raised regarding leadership. General practitioners commented on their perceptions of leadership:

- *GPs have a role as a leader;*
- *The budget holder is the leader;*
- *GPs are entrepreneurs.*

Community nurses proffered the following views on leadership:

- *The GP is the leader of the primary care team;*
- *Leadership skills are constituted by a good listener;*
- *Nurses who become leaders generally leave practice;*
- *There should be fast tracking of people with leadership potential;*
- *There is the view that nurses are told they must be managers;*
- *A leader naturally has leadership qualities.*

The semi-structured interviews with senior policy makers also gave insight into attitudes to leadership generally and, in particular, the identification and development of leaders within community nursing:

- *Identification depends on existing leaders and their ability to spot and nourish good leadership potential – there are people in senior management who have not been good at that (Director of Nursing);*

- *All nurses should be given an opportunity to develop (Director of Nursing);*

- *There are people who are already strong leaders much lower down in the organisation who don't have the title 'manager'. There should be fast tracking in community nursing because it needs it at present (Director of Nursing);*

- *There is a need to be more sensitive, be more aware of developing leadership potential in community nurses. Some of it is partly self-selection, people who come forward – this need to be developed (Chief Nurse);*

- *Identifying and developing leaders is the most difficult thing of all. In nursing over the years, any nurse who had the audacity to show any leadership was soon put in her place. This all needs to be changed. A new underlying attitude to leadership within nursing must emerge (Chief Exec – Board level);*

- *Identifying leadership tends to be an intuitive thing but I suppose you could actually set about developing criteria which would revolve around clear thinking, good communication, willingness, a kind of courage, willingness to participate, willingness to work hard – perhaps these thing could make it more measurable (Director of Nursing);*

- *I feel there is a leadership crisis in nursing and that there is a lack of such people in nursing because of their socialisation (Senior Nurse Educator);*

- *There is within leadership, different levels, in management, education, in-service training, ability to communicate and as such, leaders, have a particular core that they are better at. We must in some way use every opportunity to enhance very specific skills in order to make that person the overall, the recognised overall leader (Director of Nursing).*

- *Identification of leaders is a problem. How to identify the nurse on the ground? You say 'Who's interested?' and then you have a meeting and try to work out from talking to other people who is not only interested but able (GP –LMC);*

- *We need to provide the opportunities, the testing ground, for people who think they can perform to show, to go through a rigorous developmental process and let's see how they do (Senior Nurse Manager, DHSS);*

- *There is almost a natural aggression in community nursing. We find that leaders tend to show themselves (Director of Nursing);*

- *First of all the entire culture of nursing needs to be changed. Just like that. Nursing has a tendency to eat its young. And it doesn't celebrate success at all. That's particularly true in Northern Ireland. It's begrudgery (University Head of Nursing);*

- *It is a somewhat multifaceted process. I think people should be able to self-nominate. We shouldn't be restricted in this way. Equally managers can identify people who have got potential in this area. We also need to offer assessment and development centres so that people have the opportunity to test out where they stand on this (Senior Nurse Manager, DHSS).*

The republic of Ireland's Commission on Nursing (DHC, 1998) emphasised the importance of identifying future leaders in nursing. Leadership and management courses for nurses, such as those offered at the Institute of Public Management in Dublin are seen as important in shaping future leaders in the profession.

C. Findings Regarding Generic And Specialist Roles

As alluded to in the literature review there are a number of specialist roles being developed within community nursing. This has lead to fears from some quarters that these new roles are being formulated to the detriment of generalist roles. There follows the findings on this issue.

Table 9: Delphi responses to specialisation statement 1

Greater specialisation is essential for the community nurse of the future

	Round 1 Responses (%)				Round 2 Responses (%)			
	GP	CN	PR	Overall	GP	CN	PR	Overall
Agree	42.9	76.3	87.5	70.0	46.2	92.1	100.0	82.7
Undecided	14.3	13.2	12.5	13.3	23.1	5.3	0	8.6
Disagree	42.9	10.5	0	16.7	30.8	2.6	0	8.6

Table 10: Delphi responses to specialisation statement 2 (Round 2 only since this statement was formulated from the qualitative responses in Round 1). There was some indication from the literature that an increase in specialist nurses would cause concern among generalist community nurses and other disciplines such as social workers. Results seem to confirm this.

Increased specialisation in nursing has caused greater potential for role conflict

	Round 2 Responses (%)			
	GP	CN	PR	Overall
Agree	92.3	60.5	57.1	66.9
Undecided	7.7	13.2	42.9	15.5
Disagree	0	26.3	0	17.2

Table 11: Delphi responses to specialisation statement 3

There is a risk of developing too many specialists and not enough generalists

	Round 2 Responses (%)			
	GP	CN	PR	Overall
Agree	92.3	60.5	71.4	69.0
Undecided	0	18.4	14.3	13.8
Disagree	7.7	21.1	14.3	17.2

Results from the semi-structured interviews with senior policy makers gave further insights into the prevailing attitudes to increased specialisation within community nursing. These are structured into advantages and disadvantages:

Advantages:

- *Specialist nursing posts can bridge some of the existing gaps in the community e.g. paediatric nursing in the community and tissue viability* (Director of Nursing);
- *The specialist focus on an area ultimately provides better results* (Chief Exec – Board level);
- *The resources that you have in these specialist nurses is 'expertise' and that cannot be substituted* (GP – LMC);
- *To general practice, specialist nurses have been a major advantage in terms of midwifery led ante-natal care clinic, health visitor advice baby clinics* (GP);
- *There are distinct advantages in the expertise that we have already in the community in the form of diabetes nurses, asthma nurses and chronic disease management specialists* (Director of Nursing ; Senior Nurse Manager, DHSS);
- *The training involved with increased specialisation can be nothing but positive for community nurses* (Director of Nursing);
- *The specialist nurse is vital because of early discharge from hospital. For patients who have to be cared for at home, the specialist nurse is the best option* (Royal College of Nursing);
- *All necessary skills cannot be vested in one person and specialisation helps to ease this difficulty by providing different nurses with specialist skills in different areas* (Royal College of Nursing);

Disadvantages:

- *There is a danger that specialist nurses may lose touch with the wider community nursing picture* (Director of Nursing);

- *There is a concern that non-specialist nurses in the community may become de-skilled in these specialist areas* (Director of Nursing);

- *Elitism could emerge and this must be halted from the beginning* (Director of Nursing);

- *There must be a balance struck between the generalist and the specialist, otherwise there will be no 'seamless service'* (Chief Exec – Board level x 2);

- *There is a very real danger that there will be no continuity of care due to different nurses delivering different aspects of care* (Royal College of Nursing);

- *In principle, the specialisms should be reduced in number because it is cleaner, role definition is clearer and its clearer to the public* (Director of Nursing);

- *The current divisions in nurse registration are in themselves unrealistic; we should be moving towards a single generic nurse with specialisation in respect of need* (Senior Nurse Educator);

- *Specialisms which exist in the acute sector should not be mirrored into the community sector* (Director of Nursing);

- *If the specialist nurse comes from secondary care, there can be a problem working in primary care as they don't know how the system works* (GP);

- *There is a danger of these nurses marginalising themselves in terms of their own career* (GP – LMC);

- *We must not let the generic nursing role wither away in favour of specialist roles* (Senior Nurse Manager, HSSE);

- *There is a danger of fragmentation, of having too many specialist nurses which would be confusing for the profession and the public* (Royal College of Nursing);

- *Nursing treated specialisation the wrong way round – it should be generalist at pre-registration and specialist post-registration* (University Head of General Practice);

- *The generalist must benefit from the specialist and the expertise for specialism to be fully worthwhile* (Senior Nurse Manager, DHSS);

- *Because of their effectiveness, can we ever have enough specialists to meet demand?* (Senior Nurse Manager, DHSS);

- *If specialism is going to mean breaking nurses further down into tribes leading to inter-tribal rivalry, then it a very negative concept* (Chief Exec – Trust level).

In the Commission on Nursing (DHC, 1998), there was a call in the Republic of Ireland for specialist nurses. However, there was a clear directive that these should only represent key specialisms rather than every disease category. Presently, there are few specialist nurses in primary care in Ireland. However, the Irish public health nurses who took part in the study believed that their role enabled them to have an overview of the patient and family's care (see Recommendation 2). This fits well with the concept of the Family nurse as envisaged by the World Health Organisation (Fawcett-Henesy, 1999)

D. Findings Regarding Clinical Governance

Clinical Governance is a framework that helps all professionals to continuously improve quality and safeguard standards of care. Within this present study the Delphi questionnaires sought agreement or disagreement from respondents on a number of statements regarding clinical governance. Their responses were as follows:

Table 12: Delphi responses to clinical governance statement 1

Community nurses must be given the chance to lead on clinical governance

	Round 1 Responses (%)				Round 2 Responses (%)			
	GP	CN	PR	Overall	GP	CN	PR	Overall
Agree	64.2	89.5	100.0	85.0	61.5	97.4	100.0	89.6
Undecided	21.4	10.5	0	11.7	30.8	2.6	0	8.6
Disagree	14.3	0	0	3.3	7.7	0	0	1.7

Table 13: Delphi responses to clinical governance statement 2

Community nurses must be accountable for the quality of service they provide

	Round 1 Responses (%)				Round 2 Responses (%)			
	GP	CN	PR	Overall	GP	CN	PR	Overall
Agree	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Undecided	0	0	0	0	0	0	0	0
Disagree	0	0	0	0	0	0	0	0

Discussion points from the focus groups led to several issues being raised regarding clinical governance. In particular, general practitioners raised the following points in relation to clinical governance:

- *There is a feeling of becoming more personally accountable;*
- *Clinical practice and outcomes are highlighted.*

Community nurses made the following comments:

- *Most nurses are already looking at good quality practice;*
- *Practice audit and effectiveness is of utmost importance;*
- *Clinical governance is just another buzzword – nurses must be informed.*

Results from the semi-structured interviews with senior policy makers provided insights into nurses taking the lead on clinical governance and on the skills that community nurses have to bring to the clinical governance agenda.

- *Nurses will take the lead in clinical governance. The driving force behind it will be the nurse. That's because nurses have thought about putting systems and processes in place to safeguard the patient and also to ensure that care is patient focused* (Director of Nursing);

- *I am the Director of Nursing and taking the lead on clinical governance. It is a daunting role because its an add-on to what you've really got to do and lets face it, it could be a full time job* (Director of Nursing);

- *Clinical governance is a major issue for us as nurses and I believe that nurses are ideally placed to take a lead on this* (Chief Nurse);

- *The immediate reaction is that they should take the lead. The other side to it is that it has sometimes been perceived to be a dumping onto nurses of quality issues. I feel that nurses are very well placed to take on clinical governance as a responsibility* (Director of Nursing);

- *This cannot be a uni-disciplinary approach. It must be multi-disciplinary and if this is accepted, I have no difficulty with nurses taking the lead role. Nurses would have to be very careful though to ensure that GPs and others were on board with her* (Chief Exec – Board level);

- *Most GPs will not be able to do clinical governance; it will have to be community nurses. Within that there is a huge amount of work for community nursing to do* (GP – LMC);

- *Potentially in a lot of situations, nurses will be leading. It may appear on paper that medical staff are leading it, but I think in reality it will be nurses* (Director of Nursing);

- *Nurses recognise poor standards of care more readily than others and I think nurses are more keen than other groups to get involved in clinical governance* (Royal College of Nursing);

Policy maker views on the skills that nurses have to bring to clinical governance:

- *Knowledge of the community;*
- *Grasp of the local assessment of need;*
- *Ability to identify gaps in service that would influence their care;*
- *An appreciation of the pressures on secondary care;*
- *Expertise;*
- *Commitment;*
- *Developing standards for practice;*
- *Monitoring standards for practice;*
- *Auditing.*

In the Republic of Ireland, the report *Shaping a Healthier Future* (DoH, 1994) identified the prerequisites for a quality health service. It was based upon the principles of continuous quality improvement using tools such as audit to enhance patient care. As a result of this report, the processes that underpin clinical governance are recognisable to

Irish community nurses. There is however no policy on how clinical governance will be implemented in the Republic of Ireland.

E. Findings Regarding Teamwork

Within this present study the Delphi questionnaires sought agreement or disagreement from respondents on a number of statements regarding teamwork. Their responses were as follows:

Table 14: Delphi response to teamwork statement 1

In the future community nurses must work within an effective multi-disciplinary team

	Round 1 Responses (%)				Round 2 Responses (%)			
	GP	CN	PR	Overall	GP	CN	PR	Overall
Agree	100.0	100.0	87.5	98.4	100.0	100.0	85.7	98.3
Undecided	0	0	0	0	0	0	0	0
Disagree	0	0	12.5	1.7	0	0	14.3	1.7

Table 15: Delphi responses to teamwork statement 2

Multi-disciplinary teamwork among community nurses is an essential pre-requisite for an effective health and social care service

	Round 1 Responses (%)				Round 2 Responses (%)			
	GP	CN	PR	Overall	GP	CN	PR	Overall
Agree	100.0	97.4	75.0	95.0	100.0	100.0	85.7	98.3
Undecided	0	2.6	12.5	3.3	0	0	14.3	0
Disagree	0	0	12.5	1.7	0	0	0	1.7

Table 16: Delphi responses to teamwork statement 3

There is great potential for role conflict among members of primary care teams

	Round 1 Responses (%)				Round 2 Responses (%)			
	GP	CN	PR	Overall	GP	CN	PR	Overall
Agree	64.3	84.2	50.0	75.0	92.3	84.2	85.7	84.5
Undecided	14.3	5.3	37.5	11.7	0	7.9	14.3	6.9
Disagree	21.4	0	12.5	13.3	7.7	7.9	0	8.6

Discussion points from the focus groups led to several issues being raised regarding teamwork. General practitioners raised the following points:

- *There can be friction within the team but GPs would like to forge stronger links in the community through nurse practitioners and practice nurses.*

Community nurses made the following comments:

- *There have been improvements in teamwork over the last few years;*
- *Discussion/communication within the team makes for easier teamwork;*
- *Loyalties within the team are very important;*
- *Weekly meetings are essential to working within a team;*
- *District nursing is a core structure to the team.*

In relation to team conflict, community nurses commented:

- *There is conflicting advice to patients from too many different nurses;*
- *The existing teams working in the community need to be re-thought;*
- *There is a need for re-training for nurses coming to work in the community.*

The Irish Commission on Nursing (DHC, 1998) recognised how crucial it was that nurses worked collaboratively with colleagues from other disciplines and agencies. Most of the comments alluded to above have currency in Northern Ireland and the Republic of Ireland.

F. Findings Regarding Public Involvement

In the present study it was seen as crucial that that members of the public were involved in this research process. As consumers of primary care services, they were asked for their agreement or disagreement on a number of statements regarding primary care. Their responses were as follows:

Table 17: Delphi responses to public statement 1

Community nurses of the future have to work closely in partnership with members of the public

	Round 1 Responses (%)				Round 2 Responses (%)			
	GP	CN	PR	Overall	GP	CN	PR	Overall
Agree	92.9	100.0	100.0	98.3	100.0	97.3	100.0	98.3
Undecided	7.1	0	0	1.7	0	0	0	0
Disagree	0	0	0	0	0	2.6	0	1.7

Table 18: Delphi responses to public statement 2

There is no clear understanding of the role of the community nurses among members of the public

	Round 1 Responses (%)				Round 2 Responses (%)			
	GP	CN	PR	Overall	GP	CN	PR	Overall
Agree	7.1	63.2	62.0	50.0	15.4	55.3	57.1	46.6
Undecided	14.3	10.5	12.5	11.7	30.8	15.8	28.6	20.7
Disagree	78.6	26.4	25.0	38.4	53.8	28.9	14.3	32.8

Table 19: Delphi responses to public statement 3

Members of the public feel more comfortable dealing with the community nurse than their GP

	Round 2 Responses (%)			
	GP	CN	PR	Overall
Agree	46.2	52.6	42.9	53.5
Undecided	23.1	39.5	28.6	34.5
Disagree	30.8	7.9	28.6	15.5

Table 20:Delphi responses to public statement 4

Members of the public prefer one type of nurse to visit them at home rather than a variety of different nurses

	Round 2 Responses (%)			
	GP	CN	PR	Overall
Agree	61.5	55.3	71.4	58.7
Undecided	23.1	31.6	14.3	27.6
Disagree	15.4	13.1	14.3	13.7

Table 21: Delphi responses to public statement 5

Members of the public feel more confident if they are being treated by a specialist nurse

	Round 2 Responses (%)			
	GP	CN	PR	Overall
Agree	15.4	60.5	85.7	53.4
Undecided	53.8	31.6	0	32.8
Disagree	30.8	7.9	14.3	13.8

Table 22: Delphi responses to public statement 6

The concept of the nurses' being able to prescribe medication within a GP practice is very appealing to members of the public

	Round 2 Responses (%)			
	GP	CN	PR	Overall
Agree	30.8	52.6	85.7	51.7
Undecided	69.2	42.1	14.3	44.8
Disagree	0	5.3	0	3.4

Table 23: Delphi responses to public statement 7

The concept of self diagnosis from media, electronic and literature sources is popular with the public

	Round 2 Responses (%)			
	GP	CN	PR	Overall
Agree	46.2	34.2	42.9	37.9
Undecided	15.4	44.7	42.9	37.9
Disagree	38.5	21.1	14.3	24.1

Within the policy maker interviews, the relationship between the public and primary care was explored. The policy makers were asked what role they believed the public should play in the development of primary care services. The following responses were obtained:

- *Not sure that they have any role at present. They could have a big role but not at present. I think we should be seeking the view of the public on this. Efforts should be*

made independently to assess what is thought of community nursing in Northern Ireland (Director of Nursing);

- *It is very important that we have government policy to engage the public and seek their views on how service should be provided. We always said we knew what the public need and wanted but I don't know that we ever actually asked them* (Director of Nursing);

- *We have to move forward in partnership with the public and with local communities. Therefore we need to open pathways where local communities have a greater say in how the nursing service develops* (Chief Nurse);

- *We are failing large parts of the population on the basis that we are not innovative enough or creative enough to organise ourselves in a way that makes our service amenable and accessible to the most vulnerable in our community. The only way to engage these communities is to make them active partners in these processes and so community development is a concept which is easy to say but very difficult to do* (Chief Exec – Board level);

- *The answer of course is that they should be involved but the real question is how do we involve them* (Director of Nursing);

- *There is a need for the public to not only have a say but a significant say in what services are available and how they will be provided* (Senior Nurse Educator);

- *What we really have to do is ensure that the public voice is heard. This hasn't really been worked out yet. There are issues to do with public representation, community representation, PCGs on primary care, on the Health and Social Care partnerships. But there is a commitment to ensuring that the public voice is heard* (Senior Nurse Manager, DHSS);

- *Increasingly when we talk about the public and their involvement in services and developments we get lobby groups involved and that means there are particular elements of the public that get represented. It is difficult to involve a fully representative group and that is quite a challenge (Senior Nurse Manager, DHSS).*

G. Findings regarding Education

Community nursing is an applied academic subject which involves the study of subject specific knowledge, skills and values, while drawing upon the analytical tools and knowledge of the health, social and human sciences. It is a moral activity that requires practitioners to make and implement difficult decisions about human situations that

involve the potential for benefit or harm. Within this present study the Delphi questionnaires sought agreement or disagreement from respondents on a number of statements regarding multidisciplinary education:

Table 24: Delphi responses to education statement 1

In the future community nurses should be educated with GPs

	Round 1 Responses (%)				Round 2 Responses (%)			
	GP	CN	PR	Overall	GP	CN	PR	Overall
Agree	85.7	68.4	100.0	76.7	84.6	81.6	100.0	84.4
Undecided	7.1	18.4	0	13.3	7.7	10.5	0	8.6
Disagree	7.1	13.2	0	10.0	7.7	7.9	0	6.9

Table 25: Delphi responses to education statement 2

In the future community nurses should be educated with social workers

	Round 1 Responses (%)				Round 2 Responses (%)			
	GP	CN	PR	Overall	GP	CN	PR	Overall
Agree	64.3	68.5	75.0	68.3	61.5	79.0	71.5	74.1
Undecided	28.6	18.4	12.5	20.0	30.8	13.2	14.3	17.2
Disagree	7.1	13.2	12.5	11.7	7.7	7.9	14.3	8.6

Table 26: Delphi responses to education statement 3

In the future community nurses should be educated with physiotherapists

	Round 1 Responses (%)				Round 2 Responses (%)			
	GP	CN	PR	Overall	GP	CN	PR	Overall
Agree	78.6	63.1	87.5	70.0	76.9	68.4	85.7	72.4
Undecided	14.3	26.3	12.5	21.7	15.4	21.1	14.3	19.0
Disagree	7.1	10.5	0	8.4	7.7	10.5	0	8.6

Table 27: Delphi responses to education statement 4

In the future community nurses should be educated with occupational therapists

	Round 1 Responses (%)				Round 2 Responses (%)			
	GP	CN	PR	Overall	GP	CN	PR	Overall
Agree	78.6	65.8	87.5	71.1	84.6	68.4	85.8	74.1
Undecided	14.3	23.7	12.5	20.0	7.7	21.5	14.3	17.2
Disagree	7.1	10.5	0	8.4	7.7	10.5	0	8.6

Table 28: Delphi responses to education statement 5

In the future community nurses should be educated with dieticians

	Round 1 Responses (%)				Round 2 Responses (%)			
	GP	CN	PR	Overall	GP	CN	PR	Overall
Agree	71.4	68.4	62.5	68.3	76.9	71.0	71.4	72.4
Undecided	14.3	21.1	25.0	20.0	7.7	18.4	14.3	15.5
Disagree	14.2	10.5	12.5	11.7	15.4	10.5	14.3	10.3

Table 29: Delphi responses to education statement 6

In the future community nurses should be educated with dentists

	Round 1 Responses (%)				Round 2 Responses (%)			
	GP	CN	PR	Overall	GP	CN	PR	Overall
Agree	28.6	52.6	50.0	46.6	23.1	34.2	42.9	32.7
Undecided	57.1	26.3	37.5	35.0	69.2	47.4	42.9	51.7
Disagree	14.2	21.1	12.5	18.4	7.7	18.4	14.3	15.5

Discussion points from the focus groups led to several issues being raised regarding education. For the purposes of analysis, these are subdivided into four sub-sections:

- Practical training versus academia;
- GP attitude to nurse education;
- Multidisciplinary training;
- Health promotion.

Practical training versus academia

GP comments:

- *There has to be a balance between practical training and academia;*
- *Nurse education courses are very academically based and not enough practically based.*

Community nurse comments:

- *Newly qualified nurses have the academic qualifications but little practical training;*
- *Grading issues are a big factor as regards practical training.*

Attitudes to nurse training and education

GP comments:

- *Nurses are unwilling to pass NVQs and to supervise;*
- *Comparability of nurse training;*
- *Nurse prescribing is a big issue at present.*

Multidisciplinary education in nurse training

Community nurse comments:

- *Lack of understanding at basic level of the different roles;*
- *Education with doctors is a good idea;*
- *Communication training is essential;*
- *Post graduate education must be multidisciplinary;*
- *Non-existent multidisciplinary care at present.*

Public representative comments:

- *The public are in favour of multidisciplinary education for nurses;*
- *There are major benefits to be gained for working together;*
- *There is a need to appreciate different roles.*

Results from the semi-structured interviews with senior policy makers provided insights into multidisciplinary education for community nurses, level of facilitation for

multidisciplinary education and specifically views on community nurses being educated with GPs. These views are outlined below:

Policy maker views on multi-disciplinary education for community nurses:

- *It is essential that community nurses have not only multi-disciplinary education but also that there are links with Social Services and medical care* (Director of Nursing);

- *GPs, Physiotherapists, OTs and community nurses are working together on a day to day basis and therefore they should train together – not everyone understands what the other is capable of and multi-disciplinary education should help to ease this* (Director of Nursing , DoPH);

- *There must be a balance with multi-disciplinary education. This is to ensure that the essence of community nursing is not lost and that community nursing is not turned into something that becomes so generic that anyone could do it* (Chief Nurse);

- *Without multi-disciplinary education, you cannot have the sort of integrated working, the sort of values that should inform that working and the sort of understanding of each others perspectives and each others contribution* (Chief Exec – Board level);

- *Multi-disciplinary education can be made to work in terms of using it for the core parts of the programme, with specialist modules added on* (Director of Nursing);

- *In the case of post-registration, multi-disciplinary education has been our position for many years* (Senior Nurse Educator);

- *Multi-disciplinary training is pivotal to partnerships* (Director of Nursing);

- *In principle multi-disciplinary education is the way forward but in practice it will be very difficult to facilitate* (Director of Nursing , GP);

- *Multi-disciplinary education is essential – not least because the government's stated intentions on developing primary care mean that it won't be delivered unless people learn to work together in an atmosphere of mutual trust and respect* (Senior Nurse Manager, DHSS);

- *Multi-disciplinary education is essential if we are to build any sort of primary care team* (Director of Nursing);

- *It is important that various professionals within the health service are exposed to each other at the undergraduate pre-examination stage but there are pressures. So realistically, the main part of this multi-disciplinary education will be Director of Nursing at post-graduate level* (Senior Nurse Manager, HSSE);

- *There has still never been any kind of real teamwork achieved despite numerous efforts so one of the ways to try to do that is through multi-disciplinary education* (Royal College of Nursing);

- *What is it that we are trying to achieve through multi-disciplinary education? If it is an appreciation of each other's role, then there are other ways of doing that. It is not clear on why we are doing it* (University Head of Nursing);

- *For every professional who works in the health service, multi-disciplinary education is essential – not just nurses* (Chief Exec – Board level);

- *Multi-disciplinary education is particularly useful in the areas of team building, agreeing goals and targets for services. But it is not without difficulties* (Senior Nurse Manager, DHSS);

- *In my experience multi-disciplinary education has not been particularly successful* (University Head of General Practice);

- *The real question surrounding multi-disciplinary education is 'what are we going to gain at the end of the day?'* (Royal College of Nursing).

Level of Facilitation for Multi-disciplinary education:

- *Initially, education programmes should have its core as multi-disciplinary but it is vital that clinically multi-disciplinary education is ongoing facilitating lifelong learning* (Director of Nursing);

- *A public health module would ensure that everyone could be educated together and then branch off into their own area* (Royal College of Nursing);

- *Incentives could be offered to get people to participate in multi-disciplinary education – giving points to doctors for attending multi-disciplinary events* (Chief Exec – Board level);

- *There could be joint parts of the undergraduate curriculum for health professionals* (Chief Exec – Board level).

Policy maker views on community nurses being educated with GPs:

- *The medical model is not totally applicable to the training of nursing staff in the community* (Director of Nursing);

- *With commissioning coming up, it is essential that GPs and community nurses have similar and complimentary skills and mutual education between them may facilitate this very well* (Director of Nursing);

- *It is now more appropriate than ever that GPs and community nurses share seminars and workshops, conferences, do research together and in some cases educational training together* (Chief Nurse);

- *Joint education at an early stage would be very beneficial for these reasons: to promote collegial relationships and to promote role understanding in both directions* (Director of Nursing).

In the Republic of Ireland the Commission on Nursing Report (DHC, 1998) stressed the importance of placing nurse education under scrutiny so that future professionals are in the position to exploit opportunities for role enhancement. Particular recognition was given to multidisciplinary education and its benefits.

H. Findings Regarding Communication

Most of the quality problems experienced in clinical practice can be traced to poor communications between professionals leading to poor communication with patients. Therefore, nurses, midwives and health visitors should continue to act as catalysts to the system, linking the patient with other providers and co-ordinating care across various interprofessional and interagency frontiers.

Within this present study the Delphi questionnaires sought agreement or disagreement from respondents on a number of statements regarding communication:

Table 30: Delphi responses to communication statement 1

There is good communication between community nurses and acute hospital staff

	Round 1 Responses (%)				Round 2 Responses (%)			
	GP	CN	PR	Overall	GP	CN	PR	Overall
Agree	21.4	34.2	25.0	30.0	23.1	21.1	14.3	20.6
Undecided	28.6	18.4	62.5	26.7	23.1	28.9	71.4	32.8
Disagree	50.0	47.3	12.5	43.4	53.8	50.0	14.3	46.5

Table 31: Delphi responses to communication statement 2

There is good communication between community nurses and GPs

	Round 1 Responses (%)				Round 2 Responses (%)			
	GP	CN	PR	Overall	GP	CN	PR	Overall
Agree	85.7	57.9	50.0	63.4	76.9	60.6	57.1	63.8
Undecided	14.3	21.1	25.0	20.0	23.1	21.1	28.6	22.4
Disagree	0	21.1	25.0	16.7	0	18.4	14.3	13.8

Table 32: Delphi responses to communication statement 3

There is good communication between community nurses and other outside agencies

	Round 1 Responses (%)				Round 2 Responses (%)			
	GP	CN	PR	Overall	GP	CN	PR	Overall
Agree	0	44.7	0	28.3	0	47.4	14.3	32.8
Undecided	71.4	28.9	62.5	43.4	69.2	34.2	71.4	46.6
Disagree	28.6	26.3	37.5	28.3	30.8	18.4	14.3	20.7

Focus group discussion surrounding communication highlighted three main areas. These are:

- Communication between nurses;
- Communication between GPs and nurses;
- Communication between acute and community.

Communication between nurses

Community nurses commented that:

- *Communication must be maintained between disciplines;*
- *Education of each others' role enhances communication;*
- *There is poor communication at present between nurses and it must be improved;*
- *Regular meetings are necessary;*
- *Role definition would help communication enormously.*

Communication between nurses and GPs:

GPs commented that:

- *Telephone communication is essential;*
- *Co-ordination of communication would help.*
- *There is a need for better communication and better support for the GP.*

Community nurses commented that:

- *Communication would be improved through regular meetings with GPs.*
- *Communication between acute and community sectors is crucial to quality care;*
- *Joint posts would aid communication;*
- *Comprehensively defined roles is greatly helping communication;*
- *Liaison is necessary for good communication.*

Findings Regarding New Ways of Working.

The findings from the Delphi survey, the focus groups and the policy maker interviews identified other developmental opportunities for community nursing. These included (in no order of priority):

- *Nurse prescribing;*
- *Use of new ways of Imparting Information;*
- *The public health agenda for targeting health and social need;*
- *A Continual Raising of Professional Awareness*

I. Nurse Prescribing

In a recent statement from Alan Milburn Secretary of State for Health made at the 2000 RCN Congress he stated that:

Two years ago at this Conference, Frank Dobson committed the cash to kickstart nurse prescribing. 23,000 community nurses to be trained over three years. Today I want to extend that initiative for a further three years. I can tell Congress that I am today committing a further £10 million to train a further 10,000 nurses to prescribe. For the first time nurse prescribing will be extended to hospital nurses. Another step in unlocking the talent of nurses. (Milburn 2000)

This supports the findings from this study. An increasing number of community nurses now prescribe from a restricted formulary. The result should be a swifter start to treatment and a more effective use of nurses' and doctors' time.

J. New Ways of Imparting Information

Nurses and doctors are exploring new ways of working to meet people's health and social care needs and compliment the existing pattern of traditional GP Practice. Initiatives such as NHS Direct, walk-in centres sited at convenient places such as shopping centres, community centres where no appointment is necessary and healthy living centres. These provide opportunities for nurses to help people care for themselves through more active support, information and advice.

K. The public health agenda for targeting health and social need.

From the literature review it was pointed out that while the last 20 years has brought a marked increase in prosperity, the gap in health between those at the top and bottom of the social scale has widened. Fundamentally, this health inequality is a matter of social justice and requires to be tackled.

L. Raising Professional Awareness

The findings indicate that community nurses and midwives are at the very centre of the delivery of services and are uniquely placed to influence the development of policy and the use of resources. To do this policy makers maintains that nurses must be able to work with and recognise the complex social, economic, political and cultural contexts in which health and social care practice is located and be able to communicate this effectively within the HPSS and to the wider public.

RECOMMENDATIONS

In order to rise to new challenges and to be prepared for new roles the following action points are recommended:

A. Recommendations Regarding the Commissioning of Health and Social Care

Recommendation 1
Nurses and midwives must be resourced to engage in local commissioning arrangements

ACTION: Commissioners/Trusts/Practitioners

Recommendation 2
An education and development programme should be provided to assist nurses and other health and social services personnel to engage in the commissioning process, differentiated at the following levels:

1. General raising of awareness of the commissioning agenda and process;
2. Participation in local commissioning groups;
3. Full time- commissioning and public health roles.

ACTION: Commissioners/ Education Providers

Recommendation 3
A proportion of nurses and midwives should be facilitated to gain experience and to pursue full-time careers within commissioning bodies.

ACTION: Commissioners/Professional Organisations

B. Recommendations Regarding Leadership

Recommendation 1
In community nursing, leaders are required who are prepared to engage with individuals and organisations in a range of formal and informal situations.

ACTION: Educator Providers/Practitioners

Recommendation 2
Leaders must be able and willing to appraise critically and audit their own practice and that of others while supporting the development of knowledge and practice to meet standards of higher-level practice. (See UKCC Pilot Standards - Appendix)

ACTION: Practitioners/Trusts

Recommendation 3
Career development opportunities should exist for those nurses who show leadership and nurse consultant potential. While adhering to equal opportunities principles, a 'fast-track' approach should be considered for future community nurse leaders.

ACTION: Trusts/ Commissioners/Professional Organisations

Recommendation 4
Leadership potential should be developed and resourced at all levels in community nursing.

ACTION: Commissioners/ Trusts

C. Recommendations Regarding Generic and Specialist Roles

Recommendation 1
Because of the dynamic nature of the health and social care system there is a requirement to evaluate continually the balance between generic and specialist skills required of each practitioner.

ACTION: Practitioners/Trusts/Commissioners

Recommendation 2
Comments from public representatives highlight their desire to have contact with one main nurse who have an overview of their individual needs and those of the family. This requires one nurse to have an overview of the health and social care inputs into the patient's care, to be prepared to co-ordinate interventions, and to be knowledgeable about onward referral in a timely and appropriate manner. The patient's main nurse should retain continuing responsibility for the care of the patient including the evaluation of specialist nursing inputs into the care plan.

ACTION: Practitioners/Trusts/Commissioners

Recommendation 3
There is evidence that specialist nurses make a significant contribution to better health outcomes, reduced hospital admission and lower complication rates. Commissioners and health planners, as a matter of priority, should review current provision and establish a template for the development of specialist services to local populations.

ACTION: Commissioners/Trusts

Recommendation 4
The review suggests that communication between nurses working in the community and those in secondary care or with other agencies is not good. This requires to be addressed.

ACTION: Commissioners/Trusts/Practitioners

Recommendation 5
The current inconsistencies in the employment and remuneration of Practice Nurses compared to Treatment Room Nurses needs to be addressed. It is recommended that Practice Nurses are funded 100% by the HPSS.

ACTION: DHSSPS/Commissioners

D. Recommendations Regarding Clinical Governance

Recommendation 1
Community nurses must be given the opportunity to take lead roles in clinical governance

ACTION: Commissioners/ DHDDPS

Recommendation 2
For most nurses a role in clinical governance will be about building upon and linking together many of the activities they are already involved in such as clinical audit, clinical supervision, evidence based practice and continual professional development.

ACTION: Trusts/Practitioners

Recommendation 3
To participate actively in clinical governance, nurses require an explicit and systematic approach to the development of practice with clear lines of professional accountability and clinical leadership.

ACTION: Trusts/Practitioners

E. Recommendations Regarding Teamwork

Recommendation 1
Through quality education and experience there is a need to develop a sound understanding of the inter-disciplinary approaches to health and social welfare.

ACTION: Education Providers/Trusts/Practitioners

Recommendation 2
Community nurses must develop the interpersonal and teamwork skills that allow for collaboration with others in service delivery and problem solving.

ACTION: Trusts/Education Providers/Practitioners

Recommendation 3
Nurses must work collaboratively and understand the viewpoint and experience of others while remaining aware of the limits of others' competence and of their own.

ACTION: Trusts/Education Providers/Practitioners

Recommendation 4
For the benefit of the health and social wellbeing of the population, community nurses must form strategic alliances with other agencies such as housing, education, roads, voluntary agencies and the police.

ACTION: Trusts/Practitioners

Recommendation 5
In the commissioning of services, specifications for service should highlight, where appropriate, the requirement for effective multi-skilling, and multi-disciplinary teamwork.

ACTION: Commissioners

F. Recommendations Regarding Public Involvement

Recommendation 1
Nurses of the future have to work harder at involving the public in planning and delivering services;

ACTION: Practitioners

Recommendation 2
Community nurses must also involve users of health and social services in ways that increase the user's resources, capacity and power to influence those factors affecting their health and well-being.

ACTION: Practitioners

Recommendation 3
Nurses have a special relationships with the public and this demands a readiness to ask people about their experiences of health and how they want their care needs met

ACTION: Practitioners

Recommendation 4
Commissioners and Trusts must create a climate and culture that is responsive to public involvement, reflected in the resources, timescales, information exchange and willingness to support individual practitioners in their public engagement.

ACTION: Commissioners/Trusts

Recommendation 5
Nurses at Board level should invest in developing strategies for involving the public in service planning and provision.

ACTION: Commissioners

G. Recommendations Regarding Education

Recommendation 1
Community nurses should continue to share educational content with other disciplines.

ACTION: Education Providers/Practitioners

Recommendation 2
There are skills that are generic to the whole primary care team. These include: clinical skills, communication, ethics and professional behaviour, record keeping, management techniques, patient education, public health, and community development. Consideration should be given to these being taught in a multidisciplinary programme.

ACTION: Education Providers/Practitioners

Recommendation 3
Integrated professional educational programmes should be established, incorporating the following principles:

- standardised professional standards for the same clinical skill;
- differential standards for specialist skills;
- criteria for the practice of clinical skills to maintain competence;
- mechanisms for testing and revalidation of skills.

ACTION: Practitioners/Education Providers/Professional Bodies.

H. Recommendations Regarding Communications

Recommendation 1
Communication between community nurses and GPs is perceived as being good. However, every effort must be made to ensure this is improved further.

ACTION: Trusts/Practitioners

Recommendation 2
Commissioners should call for communication audits to be carried out on a regular basis in their health board area.

ACTION: Commissioners

Recommendation 3
Multidisciplinary education and public involvement in decision making will aid greatly the establishment of robust communication networks.

ACTION: Education Providers/Practitioners/Trusts

I. Recommendations Regarding Nurse Prescribing

Recommendation 1
The nurse prescribing formulary needs to be expanded to include a wider spectrum of treatment and prescribing rights extended to specialist nurses and practice nurses

ACTION:DHSSPS/Commissioners

Recommendation 2
85.7% of the study's public representatives wanted nurses to be able to prescribe medication within a GP practice

ACTION:DHSSPS/Commissioners/Practitioners

J. Recommendations Regarding New Ways of Imparting Information

Recommendation 1
Commissioners and managers have to undertake a more proactive approach to consider how such initiatives can be developed, exploiting the use of modern communication and information technology for service delivery.

ACTION: Commissioners/Trusts

Recommendation 2
Community nurses must be educated to use health informatics and computer systems to better support clients, families and colleagues

ACTION: Education Providers/Practitioners/DHSSPS

K. Recommendations Regarding Targeting Health And Social Need.

Recommendation 1
Community nurses must continue to be supported to develop the public health component of their role.

ACTION: Practitioners/Trusts

Recommendation 2
Commissioners must contribute to the reduction or elimination of existing inequalities in health and social wellbeing by improved targeting of strategies and services

ACTION: Commissioners

Recommendation 3
Community nurses must bring about greater participation by communities and individuals in articulating and responding to their health and social needs

ACTION: Practitioners

L. Recommendations Regarding Raising Professional Awareness

Recommendation 1
Nurses and midwives should be encouraged to organise into locality forums and specialist groupings (where appropriate) to consider and articulate a resolved view on health and social care issues.

ACTION: DHSSPS/Commissioners

Recommendation 2
Links between locality forums, the Commissioner and other professional groups within the HPSS should be fostered.

ACTION: DHSSPS/Commissioners

Primary care nursing is essentially about making health and social care more accessible to local communities and tackling the social and environmental problems at the root of many people's ill health and social exclusion. This report highlights the need for a co-ordinated approach to the development of primary care nursing, an approach that reflects health and social care policy, the emerging and extended roles of nurses and the inter-relationship between these roles and the work of other members of the primary care team.

In the next millennium, nurses, midwives and health visitors in Northern Ireland will be judged on their ability to provide sensitive, equitable and high quality services through a range of public and private sector bodies, through strengthening voluntary and community sector infrastructures and through contributing to the development of the individual empowerment of citizens for their own health care.

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APPENDIX 1

Delphi Questionnaire

Round One

Development of Primary Care Nursing (SHHSB/WHSSB)

Delphi Consensus Round 1

Please circle your response on the scale from strongly agree to strongly disagree.

(1) In the future community nurses must work within an effective multi-disciplinary team SA A N D SD

Please elaborate as necessary:

_____
_____
_____

(2) Multi-disciplinary teamwork among community nurses is an essential pre-requisite for an effective health and social care service SA A N D SD

Please elaborate as necessary:

_____
_____
_____

(3) There is great potential for role conflict among members of primary care teams SA A N D SD

Please elaborate as necessary:

_____
_____
_____

(4) Greater specialisation is essential for the community nurse of the future (eg diabetic nursing, cancer nursing) SA A N D SD

Please elaborate as necessary:

_____
_____
_____

(5) Community nurses of the future have to work closely in partnership with members of the public. SA A N D SD

Please elaborate as necessary:

_____
_____
_____

(6) The community nurses of the future should take the lead in the identification and assessment of needs of their local population SA A N D SD

Please elaborate as necessary:

_____
_____
_____

(7) Community nurses do not have the skills to take a lead role in commissioning SA A N D SD

Please elaborate as necessary:

_____
_____
_____

(8) Community nurses require training and education to take on new roles in commissioning SA A N D SD

Please elaborate as necessary:

_____
_____
_____

(9) Community nurses must have equal remuneration with GPs for roles in commissioning SA A N D SD

Please elaborate as necessary:

_____
_____
_____

(10) Community nurses require training and education to take on new roles in health care delivery in order to meet the needs of their local population SA A N D SD

Please elaborate as necessary:

_____
_____
_____

(11) There is no clear understanding of the role of the community nurse among:

(a) Members of the public SA A N D SD

(b) General practitioners SA A N D SD

(c) Social workers SA A N D SD

(d) Physiotherapists SA A N D SD

(e) Occupational Therapists SA A N D SD

Please elaborate as necessary:

_____
_____
_____

(12) In the future community nurses should be educated with:

(a) General Practitioners SA A N D SD

(b) Social Workers SA A N D SD

(c) Physiotherapists SA A N D SD

(d) Occupational Therapists SA A N D SD

(e) Dieticians SA A N D SD

(f) Dentists SA A N D SD

(g) Chiropodists SA A N D SD

Please elaborate as necessary:

_____
_____
_____
_____
_____

(13) Strong leadership is essential for the development of community nursing SA A N D SD

Please elaborate as necessary:

_____
_____
_____

(14) Currently there is strong leadership to carry community nursing into the future SA A N D SD

Please elaborate as necessary:

_____
_____
_____

(15) Staff recruitment and retention could inhibit the development of community nursing in the future SA A N D SD

Please elaborate as necessary:

_____
_____
_____

(16) Community nurses of the future will be less involved in patient care and more involved in management SA A N D SD

Please elaborate as necessary:

_____
_____
_____

(17) There is good communication between community nurses and:

(a) Acute hospital staff SA A N D SD

(b) General Practitioners SA A N D SD

(c) Other outside agencies SA A N D SD

Please elaborate as necessary:

_____
_____
_____

(18) Community nurses must be given the opportunity to lead on clinical governance SA A N D SD

Please elaborate as necessary:

_____
_____
_____

(19) Community nurses must be accountable for the quality of service they provide SA A N D SD

Please elaborate as necessary:

_____
_____
_____

(20) The community nurse is ideally placed to take a lead role in public health/health promotion SA A N D SD

Please elaborate as necessary:

_____
_____
_____

(21) Community health services in North and South of Ireland must establish stronger links SA A N D SD

Please elaborate as necessary:

_____
_____
_____

(22) Primary Care will undertake an increasing proportion of the work currently done in hospital or secondary care settings SA A N D SD

Please elaborate as necessary:

_____
_____
_____

(23) With increasing access to technology, the proportion of investigations and diagnostic tests within Primary Care will increase SA A N D SD

Please elaborate as necessary:

_____
_____
_____

(24) With the increase in our understanding of genetics, Primary Care will play a greater role in proactive health care/medicine SA A N D SD

Please elaborate as necessary:

_____
_____
_____

(25) Primary Care is ideally placed to facilitate Community Development approaches to health and social care delivery SA A N D SD

Please elaborate as necessary:

_____
_____
_____

(26) Primary Care has a key role in Targeting Health and Social Need SA A N D SD

Please elaborate as necessary:

_____
_____
_____

(27) Primary Care is well resourced to take forward extra initiatives SA A N D SD

Please elaborate as necessary:

_____
_____
_____

We would be grateful if you could complete the demographic details overleaf .

Thank you for taking the time to complete this questionnaire

Demographic Details

This information will be confidential. Your name and address are required as the second round of the Delphi Consensus is a postal round.

Please tick the appropriate box:

GP ☐ Community Nurse ☐ Public Representative ☐

If GP, please state fundholding or non-fundholding: _____

If Community Nurse, please specify exact speciality: _____

If Public Representative, what contact have you had with primary care services: _____
_____
_____

Name: _____

Address: _____
_____
_____
_____

Please tick the appropriate box:

Number of years in practice:

- One to five ☐
- Six to ten ☐
- Eleven to fifteen ☐
- Sixteen to twenty ☐
- Over twenty ☐

Please state professional qualifications:
_____
_____
_____
_____

Please tick appropriate box:

Northern Ireland based ☐

Republic of Ireland based ☐

APPENDIX 2

Delphi Questionnaire

Round Two

Development of Primary Care Nursing (SHHSB/WHSSB)

Delphi Consensus Round 2

Through the use of the Delphi technique this study aims to explore perceptions of the function, role and structure of community/primary care nursing as we enter the next millennium. The Delphi technique consists of two or more rounds where you can see how the group as a whole answered the questions and compare this to how you responded. The purpose of this is to achieve consensus on the issues raised.

You recall that you were asked to complete a questionnaire at the focus group day in December. Thank you for doing this, the responses raised a number of important issues. These responses have been analysed and have formed the basis for a second questionnaire. This questionnaire is in two sections. Section one examines the issues raised from the first Delphi questionnaire and section two incorporates the comments made in both the first questionnaire and the focus groups.

In section one, there is a series of statements concerning the future of community/primary care nursing. There are three columns beside each statement showing:

(1) The overall sample average response;
(2) Your individual response from round one of the Delphi;
(3) Space to insert your new response.

It is normal for respondents to change their first round responses; please feel free to do this or equally you can keep your response the same as in the first questionnaire. Responses are the same as before:

SA	Strongly agree
A	Agree
N	Neither agree or disagree
D	Disagree
SD	Strongly disagree

Please insert one of these abbreviations in the 'new response' column.

Delphi Questionnaire Round Two (1)

	Overall sample average	Your individual response (1st)	Your new response
In the future community nurses must work within an effective multidisciplinary team	SA		
Multidisciplinary teamwork among community nurses is an essential pre-requisite for an effective health and social care service	SA		
There is great potential for role conflict among members of primary care teams	A		
Greater specialisation is essential for the community nurse of the future	A		
Community nurses of the future have to work closely in partnership with members of the public	A		
The community nurse of the future should take the lead in the identification and assessment of needs in their local population	A		
Community nurses do not have the skills to take a lead role in commissioning	D		
Community nurses require training and education to take on new roles in commissioning	A		
Community nurses must have equal remuneration with GPs for roles in commissioning	A		

	Overall sample average	Your individual response (1st)	Your new response
Community nurses require training and education to take on new roles in health care delivery in order to meet the needs of their local population	A		
There is no clear understanding of the role of the community nurse among members of the public	N		
There is no clear understanding of the role of the community nurse among GPs	D		
There is no clear understanding of the role of the community nurse among social workers	N		
There is no clear understanding of the role of the community nurse among physiotherapists	N		
There is no clear understanding of the role of the community nurse among occupational therapists	N		
In the future community nurses should be educated with GPs	A		
In the future community nurses should be educated with social workers	A		
In the future community nurses should be educated with physiotherapists	A		
In the future community nurses should be educated with occupational therapists	A		

	Overall sample average	Your individual response (1st)	Your new response
In the future community nurses should be educated with dieticians	A		
In the future community nurses should be educated with dentists	N		
Strong leadership is essential for the development of community nursing	SA		
Currently there is strong leadership to carry community nursing into the future	N		
Staff recruitment could inhibit the development of community nursing in the future	A		
Community nurses of the future will be less involved in patient care and more involved in management	D		
There is good communication between nurses and acute hospital staff	N		
There is good communication between nurses and GPs	A		
There is good communication between nurses and other agencies	N		

	Overall sample average	Your individual response (1st)	Your new response
Community nurses must be given the opportunity to lead clinical governance	A		
Community nurses must be accountable for the quality of service they provide	SA		
The community nurse is ideally placed to take a lead role in public health/health promotion	SA		
Community health services in the North and South of Ireland must establish stronger links	SA		
Primary care will undertake an increasing proportion of the work currently done in hospital or secondary care settings	SA		
With increasing access to technology, the proportion of investigations and diagnostic tests within primary care will increase	A		
With the increase in our understanding of genetics, primary care will play a greater role in proactive health care/medicine	A		
Primary care is ideally placed to facilitate community development approaches to health and social care delivery	SA		
Primary care has a key role in targeting health and social need	SA		
Primary care is well resourced to take forward extra initiatives	D		

APPENDIX 3

Policy Maker Interview Schedule

DEVELOPMENT OF PRIMARY CARE NURSING PROJECT

POLICY MAKER INTERVIEWS

INTERVIEW SCHEDULE

SPECIALISM

Do you feel there are any advantages in increasing specialisation within community nursing?

If not, why not?

If yes:

- what direction do you see this taking?
- what do you think the benefits would be?
- do you see any potential problems?

RELATIONSHIP WITH THE PUBLIC

What role do the public have for developing primary care services in community nursing?

COMMISSIONING

What are your views on community nurses taking a lead role in commissioning?

- what skills do you feel nurses need to take on this role?
- do community nurses have the skills at present to take this role in commissioning?
- how do you envisage these skills being maintained/developed?

If community nurses do have a role in commissioning, do you believe they should have equal remuneration with GPs for this role?

EDUCATION

Do you believe that in the future community nurses should be educated with other disciplines such as GPs, Ots, Physiotherapists?

- have you any suggestions as to how this could be facilitated?

LEADERSHIP

How can potential leaders be identified and developed within community nursing?

CLINICAL GOVERNANCE

Do you believe that community nurses should be given the opportunity to lead on clinical governance?

- If no, why not?
- If yes, why do you believe they should be given this opportunity?
- What specific skills have they to bring forward this agenda?

MOVE OF SERVICES FROM SECONDARY TO PRIMARY CARE

What do you believe has been the effect on community nurses of the increasing movement of services from secondary care to primary care?

RESOURCES

What are your views on the adequacy of resourcing in terms of primary care meeting the new agenda?

PUBLIC HEALTH AGENDA

What are your views on community nursing taking a lead role in public health and health promotion?

DIRECT PATIENT CARE

What is your view on the increasing number of health care assistants taking on community nurse roles?

FINAL QUESTION

If you were to choose three developmental opportunities for the development of primary community nursing over the next five years, what would they be?

OTHER ISSUES

Have you anything further you would like to add?